NEW PATIENT INFORMATION FORM

NAME (Last, First, Middle): _____ TITLE: _____

HOME ADDRESS: _____

PREFERRED NAME: _____ SS#: _____ DOB: _____/_____/_____

HOME PHONE _____ EMAIL ADDRESS: _____

WORK PHONE: _____ SEX: Male / Female REF. PATIENT/DOCTOR: _____

CELL PHONE: _____ EMERGENCY CONTACT (Someone not living with you): _____

MARITAL STATUS: SINGLE, MARRIED, DIVORCED, PARTNERED, WIDOWED: _____

PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

SS#: _____ EMPLOYER: _____

DOB: _____/_____/_____ EMPLOYER ADDRESS: _____

PLAN NAME: _____ GROUP NO: _____

INSURANCE CO. _____ IND YRLY DEDUCT: _____

ADDRESS: _____ FAMILY YRLY DEDUCT: _____

SECONDARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

SS#: _____ EMPLOYER: _____

DOB: _____/_____/_____ EMPLOYER ADDRESS: _____

PLAN NAME: _____ GROUP NO: _____

INSURANCE CO. _____ IND YRLY DEDUCT: _____

ADDRESS: _____ FAMILY YRLY DEDUCT: _____

AUTHORIZATION OF ASSIGNED BENEFITS AND RECORDS RELEASE

I authorize Dr. Mary Lynne McElhaney to release dental information to submit insurance claims and for other physician's request relating to my dental care. I authorize payment of insurance benefits for any unpaid professional charges directly to Dr. Mary Lynne McElhaney. I understand that I am responsible for any amount not covered by my insurance.

Signature Date

_____ _____

All charges are due at the time of service. If you have insurance, you are responsible for 50% at each visit. If insurance pays more than 50% we will issue you a refund check. If the insurance does not pay within 90 days, the full amount is due by the patient or responsible party.

CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM - Please indicate corrections.

LAST NAME: _____ TITLE: _____ FIRST NAME: _____

MIDDLE NAME: _____ PREFERRED NAME: _____

REFERRING DOCTOR: _____ REFERRING PATIENT: _____

MEDICAL ALERTS: _____

MEDICAL HISTORY:

Date of last physical exam: _____

Are you now or have you recently been under a physician's care? ____YES ____NO

Reason: _____

Have you ever been a patient in a hospital or had any serious illness? ____YES ____NO

Explain: _____

Check any of the following that you have had or suspected:

YES	NO		YES	NO		YES	NO	
____	____	Arthritis	____	____	Hepatitus or Jaundice	____	____	Prolonged Bleeding
____	____	Rheumatic Fever	____	____	Liver Disease	____	____	Fainting Tendency
____	____	Heart Trouble	____	____	Cancer or Tumor	____	____	Epilepsy
____	____	Heart Murmur	____	____	Tuberculosis	____	____	Thyroid Disease
____	____	High/Low Blood Pressure	____	____	Diabetes	____	____	Glaucoma
____	____	Chest Pain	____	____	Kidney/Bladder Trouble	____	____	Radiation Treatment
____	____	Stroke	____	____	Anemia	____	____	Mental Disorders
____	____	Shortness of Breath	____	____	Lung Disease	____	____	HIV or AIDS
____	____	Asthma or Hay Fever	____	____	Veneral Disease	____	____	Prostetic Joint Replacement
____	____	Sinus Trouble	____	____	Blood Disease	____	____	Blood Transfusion

Check any of the following that you are taking or have taken:

____ Cortisone Drugs	____ Anticoagulants	____ Tranquilizers
____ Steroids	____ Blood Thinners	____ Sedatives

Are you taking any other medications? ____YES ____NO If Yes, explain:_____

_____

Are you allergic to or do you suffer any ill effects from any of the following?

____ Penicillin	____ Codeine	____ Dental Anesthesia
____ Aspirin	____ Household Bleach	____ Other: _____

WOMEN ONLY: Are you pregnant? ____YES ____NO

If Yes, how many months? ____ Are you breastfeeding? _____

Are you presently taking medicine of any kind routinely? (birth control pills, shots or implants, hormone therapy, etc.)

Explain: _____

The above information is true to the best of my knowledge.

RESPONSIBLE PARTY FOR PATIENT:

Name and Address: _____

Signature: _____

Mary Lynne McElhaney, DDS

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

  _____
- ❑ Other: _____

  _____

Prepared By _____

Signature _____

Date _____