Matthew**McGee** DMD

CHART # _____

OFFICE USE ONLY

McGee Dental, LLC
211 N. Buffalo, Suite B | Las Vegas, Nevada 89145
Tel: (702) 360-4200 Fax: (702) 869-8856
www.lasvegasdmd.com

PATIENT INFORMATION

DATE_____ **DATE OF LAST DENTAL VISIT** _____

NAME _____

PREFERRED _____

☐ **MALE** ☐ **FEMALE** **DATE OF BIRTH**_____ **SSN#**_____

MARITAL STATUS: ☐ **MARRIED** ☐ **SINGLE** ☐ **CHILD** ☐ **OTHER**_____

PHONE (CELL)_____**(OTHER)**_____

PATIENT EMAIL _____

BILLING ADDRESS _____

APT# OR SUITE# _____

CITY _____**STATE**_____ **ZIP**_____

Whom may we thank for referring you to McGee Dental?

_____

PATIENT CURRENT MEDICAL STATUS

Please list all medications you are currently taking: _____

_____

Have you been hospitalized during the past two years? ☐Yes ☐No

If yes, please explain: _____

_____

Are you now under the care of a physician? ☐Yes ☐No

If yes, please explain: _____

_____

Name of Physician: _____ Phone _____

Name of Pharmacy: _____ Phone _____

Have you ever had any complications following dental treatment ☐Yes ☐No

If yes, please explain: _____

_____

_____

_____

_____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ ALLERGIES
  - _____
  - _____
- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ARTIFICIAL JOINTS
- ☐ ASTHMA
- ☐ BLOOD DISEASE
- ☐ CANCER
- ☐ CODEINE ALLERGY
- ☐ DIABETES
- ☐ DIZZINESS
- ☐ EPILEPSY
- ☐ EXCESSIVE BLEEDING
- ☐ FAINTING
- ☐ GLAUCOMA
- ☐ GROWTHS
- ☐ HAY FEVER
- ☐ HEAD INJURIES
- ☐ HEART DISEASE HEART MURMUR
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ JAUNDICE
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ MENTAL DISORDERS
- ☐ NERVOUS DISORDERS
- ☐ PACEMAKER
- ☐ PENICILLIN ALLERGY
- ☐ PREGNANCY
  - Due Date: _____
- ☐ RADIATION TREATMENT
- ☐ RESPIRATORY PROBLEMS
- ☐ RHEUMATIC FEVER
- ☐ RHEUMATISM
- ☐ SINUS PROBLEMS
- ☐ STOMACH PROBLEMS
- ☐ STROKE
- ☐ TUBERCULOSIS
  - ☐ CHRONIC COUGH, >3WEEKS
  - ☐ BLOODY SPUTUM
  - ☐ UNEXPLAINED WEIGHT LOSS
  - ☐ NIGHT SWEATS
  - ☐ RECENT TRAVEL OUTSIDE USA
  - ☐ TUBERCULOSIS PATIENT IN YOUR HOME
- ☐ TUMORS
- ☐ ULCERS
- ☐ VENEREAL PRESEASON
- ☐ OTHER
  - _____
  - _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

OFFICE NOTES:

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SPOUSE OR RESPONSIBLE PARTY INFORMATION

THE FOLLOWING IS FOR: ☐THE PATIENT'S SPOUSE ☐THE PERSON RESPONSIBLE FOR PAYMENT

NAME _____ ☐ MALE ☐ FEMALE ☐ MARRIED ☐ SINGLE ☐ CHILD ☐ OTHER

SOCIAL SECURITY#: _____ **BIRTH DATE:** _____ **EMAIL** _____

PHONE (HOME) _____**(WORK)** _____**EXT**_____ **(CELL)**_____

ADDRESS _____**CITY** _____ **STATE** _____ **ZIP** _____

EMPLOYMENT INFORMATION

THE FOLLOWING IS FOR: ☐ THE PATIENT ☐THE PERSON RESPONSIBLE FOR PAYMENT

EMPLOYER NAME: _____**OCCUPATION:**_____

ADDRESS _____**CITY** _____ **STATE** _____ **ZIP** _____

INSURANCE INFORMATION

PRIMARY

NAME OF INSURED: **IS INSURED A PATIENT?** ☐ YES ☐ NO

_____
LAST FIRST MI

INSURED'S BIRTH DATE: _____**ID#** _____**GROUP#**_____

INSURED'S ADDRESS _____**CITY** _____ **STATE** _____ **ZIP** _____

INSURED'S EMPLOYER NAME: _____

ADDRESS _____**CITY** _____ **STATE** _____ **ZIP** _____

PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

INSURANCE PLAN NAME AND ADDRESS:_____

ADDRESS _____**CITY** _____ **STATE** _____ **ZIP** _____

SECONDARY

NAME OF INSURED: **IS INSURED A PATIENT?** ☐ YES ☐ NO

_____
LAST FIRST MI

INSURED'S BIRTH DATE: _____**ID#** _____**GROUP#**_____

INSURED'S ADDRESS _____ **CITY**_____**STATE**_____ **ZIP**_____

INSURED'S EMPLOYER NAME: _____**EMPLOYER EMAIL** _____

ADDRESS _____**CITY** _____ **STATE** _____ **ZIP** _____

PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

INSURANCE PLAN NAME AND ADDRESS:_____

ADDRESS _____**CITY** _____ **STATE** _____ **ZIP** _____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangement must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangement, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 3.5% per month (18% per annum) on the unpaid balance will be charged on all account exceeding 60 days, unless previously written financial arrangement are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) day of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all sots and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Signature of patient, parent or guardian _____ **Date** _____ **Relationship to Patient** _____

Signature of guarantor of payment/responsible party _____ **Date** _____ **Relationship to Patient** _____

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FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to providing you with the best possible care. We expect you to keep your appointments and pay your bills. The following is a statement of our Financial Policy that we require you read and sign. **Payment is due at the time of service. For your convenience we accept cash, checks, Visa, MasterCard, American Express, CareCredit or Discover.**

We accept most insurance plans, and as a courtesy, we will bill your insurance for covered dental services. You are responsible for co-payments, percentages, deductibles, and non-covered services. These payments are due at the time of service. After receipt of your insurance payment, depending on your particular insurance contract, you will be billed for any remaining balance. All remaining balances due over 90 days will be referred to collections. Any and all collection fees will be added to the balance collected.

Some dental insurances require prior authorization. We will obtain the authorization for you, however, pre-authorizations are not a guarantee of payment. Should your eligibility status change during the time period of your treatment, it is your responsibility to notify the front office staff of the change in your benefits.

No-Show Policy: We have continued to keep costs down for our patients over the past years by understanding the importance of keeping the patient's out of pocket expense to a minimum. This is only possible though, if when appointments are made, appointments are kept. Failed appointments are extremely costly, therefore as of January 1, 2003, we will be charging $50 for any failed appointment or cancellation less than 24 hours prior to your scheduled appointment time. This fee cannot be billed to your insurance and is your responsibility. Although we will continue to give a courtesy responsibility to keep track of your appointment the day before your appointment date, it is ultimately your responsibility to keep track of your appointment.

I have read and agree to the terms outlined in this financial statement.

Patient's Name: _____

Guarantor's name (if different than patient):_____

Signature: _____ **Date:** _____

CHECK ACCEPTANCE POLICY

We gladly accept your check as payment. However, in an effort not to inconvenience you in the unlikely event those funds are dishonored, we reserve the right to re-present the item electronically, plus the state allowed fee of $25.00 and any applicable taxes.

I understand and authorize all dishonored checks plus a processing fee with applicable taxes to be electronically debited from my account.

Guarantor's name (if different than patient):_____

Signature: _____ **Date:** _____

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ___ _____

Signature of Privacy Officer

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WEB AND SOCIAL MEDIA RELEASE FORM

_____ has my permission to have his/her dental work
(PATIENT NAME)

and/or photographs posted within our dental practice and/or on our website, social media accounts, videos or slide shows presentations, print ads and all other marketing or advertising efforts that promote our dental practice.

_____ _____
PATIENT SIGNATURE **DATE**

_____ _____
OVER 18 YEARS / PARENT/GUARDIAN SIGNATURE **DATE**