

**PATIENT INFORMATION**

DATE \_\_\_\_\_

NAME \_\_\_\_\_  
LAST FIRST M MARRIED SINGLE MINOR MALE FEMALE

SOCIAL SECURITY # \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET APT.# CITY STATE ZIPBIRTHDATE \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_

IF FULL TIME STUDENT, SCHOOL NAME \_\_\_\_\_ GRADE \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: PATIENT GUARDIAN SPOUSE FATHER MOTHER**INSURANCE INFORMATION**MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION  
ADULTS - COMPLETE PRIMARY INSURED  
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY				SECONDARY INSURED			
LAST	FIRST	M		LAST	FIRST	M	
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME	WORK	CELL	E-MAIL	HOME	WORK	CELL	E-MAIL
BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT		BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT	
EMPLOYER		DENTAL INS. CO		EMPLOYER		DENTAL INS. CO	
SS#	SUBSCRIBER #	GROUP #		SS#	SUBSCRIBER #	GROUP #	

**PERSON TO CONTACT IN CASE OF EMERGENCY**

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/ZIP \_\_\_\_\_

Telephone # \_\_\_\_\_

Has any member of your family ever been treated in our office?

Yes No

Whom may we thank for referring you to our office?

\_\_\_\_\_

**AUTHORIZATION**

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X \_\_\_\_\_  
Patient or Responsible Party

Date \_\_\_\_\_ State Driver's License # \_\_\_\_\_

**METHOD OF PAYMENT**

Responsible party currently has an account with this office

Yes NoPayment in full at each appointment (cash or personal check)Payment in full at each appointment ( VISA MC OTHER)

Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_

I wish to discuss the Dental Office's Financial Policy**SERVICE CHARGE**

If I do not pay the entire new balance within \_\_\_\_\_ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of \_\_\_\_\_% per month (or a minimum charge of \$\_\_\_\_\_ for a balance under \$\_\_\_\_\_ ) which is an annual percentage rate of \_\_\_\_\_% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

**DENTAL HISTORY**

Please Circle

- Do you think you have a specific dental problem? Describe \_\_\_\_\_ Yes No
- Do you like your smile? Why? \_\_\_\_\_ Yes No
- Do you ever have clicking, popping or discomfort in the jaw joint \_\_\_\_\_ Yes No
- Do you brux or grind your teeth? \_\_\_\_\_ Yes No
- Do you smoke or chew tobacco? \_\_\_\_\_ Yes No
- How do you take care of your teeth? \_\_\_\_\_
- Is there anything we can do for you to make your dental visits easier? \_\_\_\_\_

**MEDICAL HISTORY**

- Are you under a physician's care now? Why? \_\_\_\_\_
- Have you ever been hospitalized or had a major operation? \_\_\_\_\_ Yes No
- Have you ever had a serious injury to your head or neck? \_\_\_\_\_ Yes No
- Are you taking any medications, pills or drugs? \_\_\_\_\_ Yes No
- Are you on a special diet? \_\_\_\_\_ Yes No
- Are you allergic to any medications or substances? Please check box below:

- Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex Rubber  Other \_\_\_\_\_

Women (Please check):  Pregnant/trying to get pregnant  Nursing  Taking oral contraceptives Discuss \_\_\_\_\_ Yes No

Do you now have or have you ever had any of the following? Please check appropriate boxes.

\*If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No			
Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur *	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Treatments (Radiation)	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia (Bleeding Problem)	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse *	<input type="checkbox"/>	<input type="checkbox"/>	Recent Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever *	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve *	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint *	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pace Maker *	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Veneral Disease	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Medicines)	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (Infectious)	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Pollen / Dust)	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained Fever	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Sputum	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had any other serious illness not checked above? Discuss \_\_\_\_\_ Yes No

Do you wish to talk to the dentist privately about any problem? \_\_\_\_\_ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X \_\_\_\_\_ Date \_\_\_\_\_

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor \_\_\_\_\_ Date \_\_\_\_\_ BP \_\_\_\_\_

History Review and Significant Findings \_\_\_\_\_

**MEDICAL UPDATES**

I have read my MEDICAL HISTORY dated \_\_\_\_\_ and confirm that it adequately states past and present conditions. If there are no exceptions please sign, date, and circle the word None.

DATE EXCEPTIONS	PATIENT SIGNATURE	BP	REVIEWED BY
_____ None	_____	_____	_____
_____ None	_____	_____	_____
_____ None	_____	_____	_____
_____ None	_____	_____	_____

# Patrick McClure DDS

9669 Huron St Ste101 | Thornton, CO, 80260 | (303) 428-1155

## Written Financial Policy

Thank you for choosing Patrick McClure DDS. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

### Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash prior to completion of care for treatment plans of \$1000 or more.

- NO INTEREST<sup>1</sup> Payment Plans<sup>2</sup> from CareCredit

- o Allow you to pay over time with NO INTEREST<sup>1</sup>
- o Convenient, low monthly payment plans<sup>2</sup> also available
- o No annual fees or pre-payment penalties

Please note:

Patrick McClure DDS requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments an alternate, pay per visit arrangement may be provided. For larger, more comprehensive treatment plans of \$1000 or more, a 50% deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.<sup>3</sup>

A fee of \$75 is charged for patients who miss or cancel more than 1 time in a calendar year without 24-hour notice.

Patrick McClure DDS charges \$35.00 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

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Patient, Parent or Guardian Signature

Date

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Patient Name (Please Print)

<sup>1</sup>If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

<sup>2</sup>Subject to credit approval

<sup>3</sup>However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.