PATIENT INFORMATION

Circle One: Dr. Mr. Mrs. Ms. Miss

Patient's Full Name:______________________________ Preferred/Nickname:______________

Home Address:______________________________ City:______________ State:_______ Zip:__________

Mailing Address: ______________________________ City:______________ State:_______ Zip:__________

Date of Birth:_______/_______/__________ Sex:__________ Social Security #: ________-________-__________

Home Phone:__________________ Cell Phone:__________________ Work Phone:__________________

Primary Phone (circle one): Home Cell Work Email:______________________________

Employer:__________________________ Occupation:__________________ No. Years Employed:________

Marital Status (circle one): Single Married Widowed Separated Divorced Spouse's Name: __________________

Spouse's DOB:______/______/_______ Spouse's SS #: _______-________-_________ Spouse's Employer:______________

Who May We Thank For Referring You To Our Office?:______________________________

DENTAL INSURANCE INFORMATION

Primary Insurance Subscriber (circle one): Self Spouse Other______________________

Insurance Company: ____________________ Group #:______________ Member ID#:______________

Insurance Co. Address:______________________________ Phone Number:______________

Do You Have Dual Coverage? ☐ Yes ☐ No If Yes, Subscriber's Name:______________________________

Insurance Company: ____________________ Group #:______________ Member ID#:______________

Insurance Co. Address:______________________________ Phone Number:______________

EMERGENCY CONTACT

Name of nearest relative not living with you:______________________________

Address:______________________________ City:__________________ State:__________

Zip:______________ Phone Number:______________________

AUTHORIZATION AND RELEASE

I certify that I have given honest and accurate information to the best of my knowledge. I authorize Dr. Michael McDade/Quality Dentistry to release my information (including the examination, diagnosis and treatment rendered to me/my dependent) to third party payers and/or health practitioners during the period such dental care was received. I authorize and request my insurance company(s) to pay directly to Dr. Michael McDade/Quality Dentistry the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

______________________________ ______________________________

PRINT Name of Patient **PRINT** Name of Responsible Party (If Applicable)

______________________________ ______________________________

SIGNATURE of Patient (or Responsible Party) **DATE**

Medical History

PRINT Patient's Name:______________________ Today's Date______________

Physician______________________ Physician's Phone #______________________ Date of Last Exam______________

Answer all questions by circling "Y" for Yes or "N" for No

1. Are you currently under medical care/treatment? -------- Y N
2. Have you ever been hospitalized or had any surgeries? ---- Y N
   If yes, please list/date______________________________
   ____
   ____
3. Are you taking **ANY** medications (prescription, over-the-counter or supplements)? ---------------------------- Y N
   If yes, please list______________________________
   ____
   ____
4. Have you ever taken Fosamax, Boniva, Actonel or any medications containing bisphosphonates? --------------- Y N
5. Do you use any tobacco products? ------------------- Y N
6. Do you use any controlled substances? --------------- Y N
7. Are you allergic to or have you ever had a negative reaction to:
   - Sulfa --------------------------- Y N
   - Penicillin ------------------------ Y N
   - Other Antibiotic:______________ Y N
   - Local Anesthetics (Novocaine, etc.) ----- Y N
   - Aspirin or NSAIDS ------------------ Y N
   - Codeine ------------------------ Y N
   - Metals (Nickel, etc.) ---------------- Y N
   - Latex --------------------------- Y N
   - Other:______________________ Y N
8. *Women Only:*
   - *a) Are you pregnant or might be pregnant?* Y N
   - *b) Are you nursing?* ------------------ Y N
   - *c) Are you taking oral contraceptives?* ---- Y N

9. Do you have or have you ever had any of the following?

Acid Reflux/GERD	Y N	Fibromyalgia	Y N	Pacemaker	Y N
Alzheimer's/Dementia	Y N	Frequently Tired	Y N	Psychiatric Care	Y N
Anemia	Y N	Glaucoma	Y N	Radiation Treatment	Y N
Angina/Chest Pain	Y N	Heart Attack	Y N	Rheumatic Fever	Y N
Anxiety	Y N	Heart Disease	Y N	Seasonal Allergies/Hay Fever	Y N
Arthritis	Y N	Hepatitis/Liver Disease	Y N	Seizures/Epilepsy	Y N
Artificial Joint (e.g. knee, hip)	Y N	High Blood Pressure	Y N	Sexually Transmitted Disease	Y N
Asthma	Y N	HIV/AIDS	Y N	Sinus Problems	Y N
Cancer	Y N	Kidney Disease	Y N	Stomach Problems/Ulcer	Y N
Chemotherapy	Y N	Leukemia	Y N	Stroke	Y N
Depression	Y N	Low Blood Pressure	Y N	Swollen Ankles	Y N
Developmental Disorder	Y N	Migraines	Y N	Thyroid Problems	Y N
Diabetes	Y N	Mitral Valve Prolapse	Y N	Tuberculosis	Y N
Eating Disorder	Y N	Multiple Sclerosis	Y N	Other:__________	Y N
Emphysema/COPD	Y N	Osteoporosis	Y N	__________	

10. How likely are you to doze off or fall asleep in the situations described to the right, (in contrast to just feeling tired)? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to remember how they would have affected you. Use the following scale to choose the most appropriate number for each situation:
    0 = Would never doze off
    1 = Slight chance of dozing off
    2 = Moderate chance of dozing off
    3 = High chance of dozing off

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. in a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

I understand the importance of divulging a complete and honest Medical and Dental History in order for the doctor(s) to provide me with the best possible dental care. I understand that providing incorrect information can be dangerous to my health. By signing below, I certify I have filled out this form truthfully.

______________________________ ______________________________

SIGNATURE of Patient (or Responsible Party) **PRINT** Name of Responsible Party (If Applicable)

Dental History

Name of Last Dentist____________________ City/State____________________

Office Phone Number (________)____________________ Date of Last Exam____________________

Date of Last Cleaning ____________________ How Often Were Your Teeth Cleaned?____________________

Reason For Today's Appointment ____________________

1. Do you feel pain in any of your teeth? - Y N ____________
2. Are your teeth sensitive to hot or cold? - Y N ____________
3. Are your teeth sensitive to sweet or sour things? - - - - - - - - - - - - - Y N ____________
4. Do your gums bleed when brushing or flossing? - - - - - - - - - - - - - - Y N ____________
5. Do you have any sores or lumps in or near your mouth? - - - - - - - - Y N ____________
6. Have you had any injuries to your head, neck or jaw? - - - - - - - - - - Y N ____________
7. Have you ever had any of the following problems in your jaw?
   - Clicking or Popping - Y N ____________
   - Pain with Opening or Closing - Y N ____________
   - Difficulty Chewing - Y N ____________
8. Have you ever been treated for Periodontal Disease? - - - - - - - - - - Y N ____________
9. Do you have frequent headaches? - Y N ____________
10. Do you clench or grind your teeth? - Y N ____________
11. Do you bite your lips or cheeks frequently? - - - - - - - - - - - - - - - - Y N ____________
12. Have you ever had any difficult extractions? - - - - - - - - - - - - - - - - Y N ____________
13. Have you ever had prolonged bleeding after an extraction? - - - - Y N ____________
14. Are you nervous or anxious about having dental treatment? - - - - Y N ____________
15. Have you ever had orthodontic treatment (braces)? - - - - - - - - - - Y N ____________

If yes, when & for how long?____________________

16. Do you wear dentures or partials? - Y N ____________

If yes, date made____________________

17. Is there anything you would like to change about your teeth or smile? - Y N ____________

If yes, please explain____________________

____

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____________________ ____________________

PRINT Name of Patient | **PRINT** Name of Responsible Party (If Applicable)

____________________ ____________________

SIGNATURE of Patient (or Responsible Party) | **DATE**

OFFICE POLICIES

Quality Dentistry
Dr. Michael McDade, DDS, PLLC

1710 LaFayette St
Steilacoom, WA 98388

&

8404 83rd Ave SW
Lakewood, WA 98498

Financial Policy

This office accepts payment in the form of cash, check, Visa, Mastercard, American Express, Discover, CareCredit and offers a 10% discount for patients that do not have insurance and pay at the time of service. As a courtesy, our office will attempt to get a breakdown of your dental insurance benefits and submit claims on your behalf; however, it is ultimately your responsibility to be knowledgeable about your own insurance policy. Your estimated portion for services is due and payable at the time of service. Once final benefit payment is received, we will send you a billing statement for any balance due. Your signature below means you agree to be financially responsible for all charges from all services and materials not paid by your dental plan or are not a covered benefit of your dental plan. Your signature below means that to the extent permitted by law, you are consenting to this dental office's use and disclosure of your protected health information to carry out payment activities in connection with all your insurance claims.

Diagnosis & Treatment Policy

Our doctors or designated staff may take x-rays, study models, photographs or other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of your dental needs. Your signature below authorizes the doctor to perform all recommended treatment mutually agreed upon by you to employ such assistance, where required, to provide proper care. Your signature below also authorizes consent to the use of appropriate medication and therapy as deemed necessary and that you understand using agents embodies a certain risk.

Appointment Policy

Appointment reminders in the form of postcards, phone calls, texts or emails are a courtesy only; patients/guardians are responsible for remembering their scheduled appointments. If you are unable to keep a scheduled appointment, we require you call our office to cancel or reschedule at least *48 hours prior to the scheduled appointment time.* If you do not call to cancel and/or reschedule a scheduled appointment at least 48 hours prior to the appointment time, you will be considered a "No Show" and will be financially responsible with a charge of *$100.00 per hour* for the missed appointment. We understand that emergencies do happen so you will not be charged for a missed appointment **due to an emergency**; however, you are required to contact us as soon as possible in the event you are unable to keep your scheduled appointment. After three (3) "No Show" appointments you may be dismissed from our practice by a Certified Letter.

Cell Phone Policy

Cell phone use is **NOT** permitted during your appointment. Since today's smart phones are also cameras, video cameras, and tape recorders, their use can lead to violations of other patient's private medical information.

Your signature below is acknowledgement that you have read and understand all of the above policies.

______________________________ ______________________________

PRINT Name of Patient | **PRINT** Name of Responsible Party (If Applicable)

______________________________ ______________________________

SIGNATURE of Patient (or Responsible Party) | **DATE**

Acknowledgement of Notice of Privacy Practices

Quality Dentistry
Dr. Michael McDade, DDS, PLLC

1710 LaFayette St
Steilacoom, WA 98388

&

8404 83rd Ave SW
Lakewood, WA 98498

I acknowledge that I have viewed, and upon request received, a copy of the *Notice of Privacy Practices* for the office(s) of Quality Dentistry/Dr. Michael McDade. The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of this office's health care operations. The *Notice of Privacy Practices* also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The *Notice of Privacy Practices* is also posted in this facility.

Quality Dentistry/Dr. Michael McDade reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices*. If privacy practices change, I will be offered a copy of the revised *Notice of Privacy Practices* at the time of my first visit after the revisions become effective. I may also obtain a revised *Notice of Privacy Practices* by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY
In addition to the allowable disclosures described in the *Notice of Privacy Practices*, I hereby specifically authorize disclosure of my protected health care information to the person(s) indicated below. ***(Check one box)***
☐ SPOUSE ONLY
☐ ANY MEMBER OF MY IMMEDIATE FAMILY
☐ OTHER (PLEASE SPECIFY)

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

____
PRINT Name of Patient

____
PRINT Name of Responsible Party (If Applicable)

____
Signature of Patient (or Responsible Party)

____
DATE

OFFICE USE ONLY BELOW THIS LINE

REASON FOR DENIAL:

☐ NEEDED MORE TIME TO REVIEW NOTICE OF PRIVACY PRACTICES
☐ WANTED TO CONSULT WITH ANOTHER PERSON BEFORE SIGNING
☐ UNABLE TO SIGN
☐ REASON NOT GIVEN
☐ OTHER: