McCart Family Dentistry

"serving the community with excellence"

Patient Information

Patient Name: _____ Date:_____
Last, First (Preferred Name) (Mr. Mrs. Miss. Dr. Minister)

How did you hear about us?_____

Emergency Contact Name:_____ Relationship:_____ Phone #:_____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Address: _____
Street City State Apartment # Zip Code

Physician Name:_____Physician Phone:_____

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: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Health History

If you are completing this form for another person, what is your relationship to that person?_____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Have you had or do you currently have:

List of Medications

Yes No Do you have a heart condition, had heart surgery or a murmur?
Yes No Have you been told by a physician that you need to be pre-medicated with anti-biotic before dental procedures (due to your heart or joint replacement)? _____
Yes No A reaction or allergy to latex or plastic resins?
Yes No Are you taking a blood thinner? (ie. Coumadin, Warfarin) _____
Yes No Do you take aspirin daily?
Yes No Diabetes? Insulin dependent or Non-insulin dependent? _____
Yes No Stroke or problems associated with a stroke?
Yes No Rheumatic fever or rheumatic heart disease? _____
Yes No High or low blood pressure?
Yes No Epilepsy or neurological disorder? _____
Yes No Thyroid condition?
Yes No Glaucoma or eye condition? _____
Yes No Respiratory disease, asthma, or respiratory allergies?
Yes No Tuberculosis or lung disease? _____
Yes No Hepatitis, jaundice, or liver disease?
Yes No Stomach,(Acid Reflux) or other internal problems?
Yes No Kidney problems? _____
Yes No Blood disorder?
Yes No Arthritis? _____
Yes No Tumors, growths, cysts, or cancer?
Yes No AIDS or HIV infection?
Yes No Sexually transmitted disease?
Yes No A reaction or allergy to any drugs or medication? If so please list below:

_____

Yes No A reaction or allergy to any material we should be aware of?
Yes No Any joint replacement? (hip, knee, etc.)
Yes No Radiation therapy or chemotherapy?
Yes No Mental disorder/ retardation?
Yes No Are you taking or have ever taken Osteoporosis medications? (ie., Fosamax, Actonel, Aredia, Zometa, Bonia)
Yes No Have you been hospitalized in the past two years?

Women only

Yes No Are you pregnant? If yes, How many months?_____
Yes No Are you taking birth control pills?
Yes No Are you nursing?

Dental History

Yes No Do you use tobacco products or snuff? If yes, How long?_____ How often?_____
Yes No Have you ever had dental anesthetic (injections)?

When was your last dental visit?_____ Reason?_____

When was your last cleaning?_____ Where?_____

When was your last full mouth x-ray?_____ Where?_____

Are you interested in whitening your teeth?_____

Are you interested in IV sedation?_____

Yes No Do you have any dental complications at the time?
If yes, please describe:_____

_____

Patient or Guardian Signature Date

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Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs 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 arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services provided are billed directly to the patients insurance. The patient is fully responsible for any unpaid/ denied charges. This office will prepare the patients insurance forms, collect payments and credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that all charges will be paid by an insurance company.

A service charge of 5% per month on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for my dental care can only be extended for a period of six months from the date of my 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 her 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 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 costs 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.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible part

Consent for Internet Communications

I grant my permission to McCart Family Dentistry to upload and store confidential patient information — including account information, appointment information and clinical information — to the secured web site for McCart Family Dentistry. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand McCart Family Dentistry and myself are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that McCart Family Dentistry is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand McCart Family Dentistry is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the McCart Family Dentistry web site with my ID and password. I also agree to immediately notify McCart Family Dentistry of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand McCart Family Dentistry will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that McCart Family Dentistry has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand McCart Family Dentistry will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand McCart Family Dentistry CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for McCart Family Dentistry, and grant McCart Family Dentistry permission to securely upload my patient information to the web site.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

Email:_____

Financial Agreement

We are pleased to welcome you as a new patient. ***Our mission: At McCart Family Dentistry honesty, reliability and a spirit of excellence is the foundation on which we build our business.*** To assist you with your dental care investment, we provide the following financial options:

1. **Cash** – includes money orders and personal checks. There is a **$30.00** returned check fee.
2. **Visa/MasterCard** – we accept credit cards as payment for treatment.
3. **Care Credit and Chase Health Advance** – patient payment plans that allow you to pay overtime with convenient low minimum monthly payments. You can enjoy these benefits with credit approval.
   - o Interest free options
   - o Flexible financing options
   - o Quick and easy application
   - o Receive a credit decision almost immediately

4. ***No Show/Late/Cancellation Policy*** – Office hours are by appointment and we do value your time. This office is a private practice and not a dental "clinic". Appointment time is reserved for you alone. We prefer to schedule longer appointments so we can complete as much dental treatment as possible during one appointment. When you make an appointment, please be sure that you will be able to keep it. As a courtesy, we will call and confirm your appointment **48 business hours** prior to your scheduled appointment.
5. **•We reserve the right to charge you *$50.00 per 30 minutes of schedule time* for no show appointments/less than 24 hours cancellation notice. _____initials**
   •If you are 10 minutes late, all procedures scheduled may not be completed. _____Initials
   •Three no show appointments or same day cancellations could result in dismissal from the practice. _____Initials
6. **Only two (2) family members may be scheduled on the same day at a time. Unless previously arrangements have been made. _____initials**

7. ***Collections***– Any account balances over 60 days will be forwarded to a collection agency and all collection fees are the patient's responsibility. _____**initials**
8. *Any balance not taken care of within **30 days** will assess a monthly **5%** finance charge of the remaining balance until paid in full.*

I have read the above office agreement and agree to the terms and conditions.

_____ _____
Patient/Guardian Signature Today's Date

Insurance Agreement

I, (patient/guardian name) _____, fully understand that it is a benefit provided to me when McCart Family Dentistry files my insurance for any service rendered or treatment performed. It is my responsibility as the insured to inform the front office staff of any changes to my insurance policy. I fully understand that McCart Family Dentistry will estimate insurance payments based on information provided by me and my insurance company. I also understand that insurance companies may disclose inaccurate information when verifying my benefits. If the insurance company does not pay for some or all services, I am fully responsible for any unpaid / denied charges. A written insurance policy is provided to me, not McCart Family Dentistry; therefore, it is also my responsibility to verify and understand my coverage.

Thank You,

McCart Family Dentistry

Signature: (patient / guardian)_____ Date:_____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Danita Bolin

Telephone: (817) 423-9300 Fax: (817) 423-9097

Address: 6801 McCart Avenue, Suite B2, Fort Worth, Texas 76133

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.