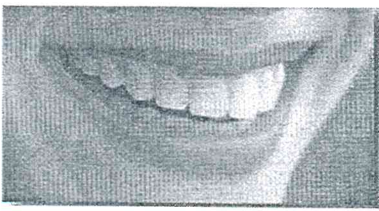


Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # ____________
SS#/SIN ____________
Date ____________

Patient Information (CONFIDENTIAL)

Patient's Sex ☐ F ☐ M

Name ____________ Birthdate ____________ Home Phone ____________
Address ____________ City ____________ State/Prov. ____________ Zip/P.C. ____________
Email ____________ Cell Phone ____________
Do you prefer to receive calls at your: ☐ Home ☐ Work ☐ Cell Phone
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College ____________ City ____________ State/Prov. ____________ ☐ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer ____________ Work Phone ____________
Business Address ____________ City ____________ State/Prov. ____________ Zip/P.C. ____________
Spouse or Parent/Guardian's Name ____________ Employer ____________ Work Phone ____________
Whom may we thank for referring you? ____________
Person to contact in case of emergency ____________ Phone ____________

Responsible Party

Name of Person Responsible for this Account ____________ Relationship to Patient ____________
Address ____________ Home Phone ____________
Email ____________ Cell Phone ____________
Driver's License# ____________ Birthdate ____________ Financial Institution ____________
Employer ____________ Work Phone ____________ SS#/SIN ____________
Is this person currently a patient in our office? ☐ Yes ☐ No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

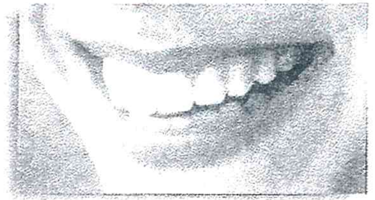
Insurance Information

Name of Insured ____________ Relationship to Patient ____________
Birthdate ____________ SS#/SIN ____________ Date Employed ____________
Name of Employer ____________ Union or Local # ____________ Work Phone ____________
Address of Employer ____________ City ____________ State/Prov. ____________ Zip/P.C. ____________
Insurance Company ____________ Group # ____________ Policy/ID # ____________
Ins. Co. Address ____________ City ____________ State/Prov. ____________ Zip/P.C. ____________
How much is your deductible? ____________ How much have you used? ____________ Max. annual benefit ____________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured ____________ Relationship to Patient ____________
Birthdate ____________ SS#/SIN ____________ Date Employed ____________
Name of Employer ____________ Union or Local # ____________ Work Phone ____________
Address of Employer ____________ City ____________ State/Prov. ____________ Zip/P.C. ____________
Insurance Company ____________ Group # ____________ Policy/ID # ____________
Ins. Co. Address ____________ City ____________ State/Prov. ____________ Zip/P.C. ____________
How much is your deductible? ____________ How much have you used? ____________ Max. annual benefit ____________

Over Please



Patient Medical History

Physician ______________ Office Phone ______________ Date of Last Exam ______________

	Yes	No
Are you under medical treatment now?	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain ______________		
Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ______________		
Have you ever taken Fen-Phen/Redux?	☐	☐
Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
Do you use tobacco?	☐	☐
Do you use controlled substances?	☐	☐
Do you have or have you had any of the following?		

	Yes	No
Are you wearing contact lenses?	☐	☐
Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other ______________		
Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other ______________	☐	☐

Patient Dental History

Name of Previous Dentist and Phone # ______________ Date of Last Exam & X-Rays ______________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement ______________		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved.
This office accepts insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. 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 release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.
I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X ______________

Signature of patient (or parent/guardian if minor) Date

Stephen P. McCulloch, DMD

101 E Commerce St. Wetumpka, AL 36092 (334) 567-7232

CANCELLATION POLICY:

We kindly ask that you give our office a 48 business hour notice to cancel or change an appointment. If no notice has been given, we reserve the right to charge you for the unrecovered time. The fee will be determined on the amount of time reserved with our Doctor/Hygienist and can range anywhere from $40-$150.

FINANCIAL POLICY:

We recognize that excellent modern dental care is not an inexpensive item in some family budgets but it remains an outstanding healthcare value. We assure you that our fees are continuously reviewed to reflect regional and national averages and account for our expertise and experience. As a team, we are committed to providing the highest quality care and in using the most modern materials and techniques available today. We give each of our patients the option for the best treatment plan and level of care.

INSURANCE POLICY:

Dr. McCulloch will diagnose what is in your best interest regarding your oral health and does not let the insurance benefits dictate his evaluation and recommendation of your personal needs. Please keep in mind that your insurance policy is a contract between you and your insurance company. Claims are submitted promptly after treatment is rendered and does not absolve the patient of responsibility for the charges in full for treatment rendered. All estimated out of pocket amounts are due will be requested at the time of service unless prior arrangements have been made.

PAYMENT POLICY:

- Payment is due at the time services are rendered.
- We accept cash, personal checks, Visa, MasterCard, Discover and AMEX.
- We offer extended and 0% interest payment options through a third party corporation.
- We encourage you to discuss any financial concerns that you may have so that we may assist you in the effective management of your account.
- Balances over 30 days will be subject to additional interest charges (1.5% per month, 18% annually). Balances over 60 days will be outsourced to a third party collection agency and credit reporting agency.

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.

You agree, in order for us to service your account or to collect monies you may owe, Dr. Stephen P. McCulloch, DMD and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Stephen P. McCulloch, DMD, its employees and/or agents may contact me/us as described above.

______________________________ ______________________

Responsible Party Signature Date

Stephen McCulloch, D.M.D.
101 E Commerce Street
Wetumpka, Al 36092

Acknowledgement of Receipt of Notice of Privacy Practices

{NAME OF PRACTICE}

You May Refuse to Sign This Acknowledgment

I have received a copy of this office's Notice of Privacy Practices.

Print Name: ______________________________

Signature: ______________________________

Date: ______________________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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