

McCulloch Family Dentistry

1194 Holtville Road
Wetumpka, AL 36092
(334)567-7232

NAME: _____
First Middle Initial Last
DOB: _____ SSN: _____
Primary phone:() _____ Cell:() _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____
Employer: _____ Phone:() _____

please circle: Minor Single Married Divorced Widowed

Parent/ Spouse: _____ Phone() _____
Emergency contact: _____ Phone() _____

Responsible Party (if not self):-----

Name: _____
First Middle Initial Last
DOB: _____ SSN: _____
Phone:() _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____

Dental Insurance Information -----

Primary insurance company: _____

Policy holder name: _____

First Middle Initial Last
DOB: _____ SSN: _____
Address: _____ City, State, Zip: _____

Secondary insurance company: _____

Policy holder name: _____

First Middle Initial Last
DOB: _____ SSN: _____
Address: _____ City, State, Zip: _____

Dr. Stephen P. McCulloch, DMD

Dr. Lee Woodall, DMD, MPH

Eaglesoft Medical History 2025(Copy)

Patient Name:

Birth Date:

Date Created:

Disclaimer

Thank you for answering the following questions.

Preferred Pharmacy	☐	If yes	_____
Are you under a physician's care now?	☐ Yes ☐ No	If yes	_____
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes	_____
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	If yes	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	If yes	_____
Do you use tobacco?	☐ Yes ☐ No		_____
Do you use controlled substances?	☐ Yes ☐ No	If yes	_____
Are you taking any blood thinners?	☐ Yes ☐ No	If yes	_____
Have you ever taken (PREMED) antibiotics prior to having any dental procedure done?	☐ Yes ☐ No	If yes	_____

Women: Are you...

☐ Pregnant☐ Nursing?☐ Trying to get Pregnant

Are you allergic to any of the following?

☐ Aspirin☐ Penicillin☐ Codeine☐ Metal☐ Latex☐ Sulfa Drugs☐ Local Anesthetics

Other?

☐

If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐ Yes ☐ No	Cortisone Medicine	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Anaphylaxis	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No
Hepatitis B or C	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Epilepsy or Seizures	☐ Yes ☐ No	Artificial Heart Valve	☐ Yes ☐ No	Artificial Joint	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No
Sickle Cell Disease	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Blood Disease	☐ Yes ☐ No
Kidney Problems	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No	Chest Pains	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No	Congenital Heart Disorder	☐ Yes ☐ No
Heart Pacemaker	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No
Yellow Jaundice	☐ Yes ☐ No	Aortic Valve Replacement	☐ Yes ☐ No				

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____

Stephen P. McCulloch, DMD

1194 Holtville Road 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.
1194 Holtville Road
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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