Patrick L. McGee, DDS
2818 Armand St. • Monroe, LA 71201
(318) 388-0828

NEW PATIENT INFORMATION

Name ______________________________
Name you go by ______________________________
Address ______________________________
City ______________ State ______ Zip ________
Home # (____)______________________________
Work # (____)______________________________
Cell # (____)______________________________
Date of Birth ______________________________
Social Security Number ______________________________
Parent/Spouse Status: ___Single ___Married ___Divorced
School ______________________________
Employed By ______________ How long? ______
Referred By ______________________________
Would you like us to contact you by email? Y/N ______
Email Address ______________________________

ACCOUNT INFORMATION

Person Responsible for Account ______________________________
Relationship to Patient ______________________________
Address ______________________________
City ______________ State ______ Zip ________
Social Security Number ______________________________
Employed By ______________ How long? ______
Home # (____)______________________________
Work # (____)______________________________
How do you plan to pay for your dental visit?

❒ Cash ❒ Credit Card ❒ Check

Would you like to apply for a dental credit card?

___ Yes ___ No

DENTAL INSURANCE INFORMATION

Name of Insured ______________________________
Relationship to Patient ______________________________
Insured's Date of Birth ______________________________
SSN ______________________________
Employed By
How long? ______________________________
Insurance Company ______________________________
Group Number ______________________________
Employee/Cert. Number ______________________________

Please provide receptionist with insurance card for your file.

AUTHORIZATION AND RELEASE

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance coverage. However, the patient is responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance with our office manager.

I hereby authorize Dr. McGee to furnish information to insurance carriers concerning treatment, and hereby assign to the dentist all payments for dental services rendered to myself and/or my dependants. I do understand that I am responsible for any amount not covered by insurance. I also agree to pay a service charge of 1.5% per month (18% annually) on any unpaid balance over 30 days. I also agree to pay any additional charges that may be incurred in the collection of my account.

Date ______________ Signature ______________________________

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How did you hear about our office? ____

What positive things have you heard about our office? ______________________________

What made you leave your last dental office? ____________________________________

What were some things that you did not like about your previous dental office? _______________

Have you had any previous bad experiences with other dentists? __________________________

What is the primary reason you delay getting your dental treatment completed?

❒ I am fearful of having dental work ❒ I don't have enough time

❒ I feel like I can't afford the work I need

What is your primary goal in joining our practice? ___________________________________

What would you say best describes you? (Please pick one)

❒ I only want to address my chief concerns.

❒ I want a comprehensive and exam and treatment plan but only want treatment that my insurance will cover.

❒ I want a comprehensive exam and treatment plan and care about obtaining the best treatment possible regardless of what my insurance benefits are.

Do you have kids/grandkids? If so, how many? ________________

What type of hobbies do you have? ____

What is your favorite restaurant? ____

Do you have pets? If so what kind? ____

Who is your favorite sports team? ____

Have you lived in places other than Monroe? ______________________________________

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GENERAL QUESTIONS

This questionnaire will be used by your dentist to help treat you safely. Please answer all questions as accurately as possible.

Do you have, or have you had an history of the following?

	Yes	No	Do not know		Yes	No	Do not know
High blood pressure				Kidney disease			
Angina / Chest pain				Renal dialysis			
Heart attack				Organ transplant			
Prosthetic heart valve				Cancer			
Pacemaker/Defibrillator				Radiation therapy			
Heart disease / surgery				Chemotherapy			
Stroke / TIA				Epilepsy / Seizure			
Emphysema / Bronchitis				Stomach / Intestinal problems			
Asthma				Arthritis			
Diabetes				Artificial joint			
Thyroid disease				Sexually transmitted disease			
Autoimmune disease / Lupus				AIDS / HIV			
Liver disease				Tuberculosis (TB)			
Hepatitis				Psychiatric treatment			
Anemia				Allergies			
Bleeding disorder				Osteoporosis			

Do you have any conditions not listed above? ❐ Yes ❐ No

If yes, please list: ______________________________

Please list any and all allergies: ______________________________

____

Please list any and all medications you are currently taking: ______________________________

____

____

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DENTAL HISTORY

Reason for visit ______________________________

When was your last dental visit? ______________________________

How often do you brush your teeth? ______________________________

Do your gums bleed when you brush or floss? ❒ Yes ❒ No

Do your teeth hurt when you brush or floss? ❒ Yes ❒ No

Are your teeth sensitive to hot, cold, sweet, or sour foods/liquids? ❒ Yes ❒ No

Have you noticed any loosening of your teeth? ❒ Yes ❒ No

Does food tend to get caught between your teeth? ❒ Yes ❒ No

Do you have any sores or lumps in or near your mouth? ❒ Yes ❒ No

Have you experienced any of the following problems in your jaw?

- Clicking? ❒ Yes ❒ No
- Pain (joint, ear, side of face)? ❒ Yes ❒ No
- Difficulty opening or closing? ❒ Yes ❒ No
- Difficulty chewing? ❒ Yes ❒ No

Have you ever had any head, neck, or jaw injuries? ❒ Yes ❒ No

Do you have frequent headaches? ❒ Yes ❒ No

Do you clench or grind your teeth while awake or asleep? ❒ Yes ❒ No

Have you ever had:

- Orthodontic treatment (braces)? ❒ Yes ❒ No
- Oral Surgery? ❒ Yes ❒ No
- Gum Treatment? ❒ Yes ❒ No
- Your teeth ground or the bite adjusted? ❒ Yes ❒ No
- Worn a bite plat or other appliance? ❒ Yes ❒ No

Are you satisfied with the appearance of your teeth? ❒ Yes ❒ No

Is there anything about having dental treatment that bothers you? ❒ Yes ❒ No

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APPOINTMENT GUIDELINES AND AGREEMENT

Since providing quality treatment for all our patients in a timely manner is a major focus in our practice philosophy, we would like to clarify our appointment guidelines with you and ask that you assist us in this endeavor.

____ There will be absolutely NO charge for your need to reschedule an appointment; provided you give us a 48 hour notice and you contact us during business hours. This would allow us to give this time to another patient who is in need and waiting for an appointment.

____ Not showing for an appointment without 48 hour notice will count as a missed appointment. Three or more missed hygiene appointments or two missed treatment appointments in 18 months will result in a RESERVATION FEE being required to schedule, being seen as a walk in only during a designated time or dismissal from the practice.

Last minute cancellations can cause hardships for many individuals. It is our sincere hope that you will accept these guidelines and join us in our efforts to provide quality time for you and each valued patient in our practice.

Thank you

_______________________________________ ______________________

(Patient) (Date)

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NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: ____ Date of Birth: _____________________

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that is maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: ____ Date: _____________________________

Relationship to patient (if signed by a personal representative of patient): ____________________________