Patient Information

Patient Name:_____ Today's Date: _____
Last First MI (Preferred Name)

Is Patient a child/dependent ☐ Yes ☐ No ☐ Male ☐ Female Married? ☐ Yes ☐ No

Social Security #: _____ Birth Date: _____ Email: _____

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

Address: _____
Street Apartment#

_____
City State Zip Code

Employer Name: _____

How did you hear about us? _____

Health Information

Date of Last Dental Visit:_____ Reason for today's visit: _____
Height: _____ Weight: _____ Date of Last Physical: _____

Have you ever been diagnosed with any of the following? (Please check all that apply):

☐ AIDS/HIV	☐ High Cholesterol	☐ Jaundice/Liver Disease	☐ Sinus Problems
☐ Allergies	☐ Diabetes	☐ Joint Replacement	☐ Stomach Problems/Ulcers
☐ Anemia	☐ Dizziness/Syncope	☐ Kidney Disease	☐ Stroke
☐ Arthritis	☐ Epilepsy/Seizures	☐ Latex Allergy	☐ St. John's Wort used
☐ Artificial Joints	☐ Pre-medication	☐ Psychiatric Disorder	☐ Tuberculosis
☐ Asthma/ Respiratory Problems	☐ Epinephrine Allergy	☐ Nervous Disorders	☐ Tumors
	☐ Blood Disorder	☐ Glaucoma	☐ Pacemaker
☐ Thyroid Problems	☐ Cancer	☐ Growths/Tumors	☐ Currently or Possibly Pregnant
☐ Venereal Disease	☐ Drink Grapefruit Juice	☐ Drug/Alcohol Abuse	
☐ Tobacco Use	☐ Smokeless Tobacco Use	☐ Head Injuries	☐ Trying to conceive?
☐ Heart Murmur	☐ Hepatitis A/B/C	☐ High Blood Pressure	☐ Low Blood Pressure
☐ Heart Disease	☐ Radiation Treatment	☐ Rheumatic Fever	☐ Cold Sores/Fever Blisters

☐ List of current medications:

_____
_____

☐ List any/all ALLERGIES to medications:

_____
_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Billing Information

The following information is for the person responsible for payment:

Patient Name:_____ Relationship to Patient:_____ ☐ Male ☐ Female
Last First MI

Social Security #: _____ Birth Date: _____ Email: _____

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

Address: _____
Street Apartment#

_____
City State Zip Code

Employer Name: _____

Insurance Information

Primary Insurance Plan Information:

Name of Insured:_____ Relationship to Patient ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other
Last First MI

Insurers Birth Date: _____ Subscriber ID: _____ Group#: _____

Insured's Address: _____
Street Apartment#

_____
City State Zip Code

Employers Name: _____

Insurance Plan Name, Address and Phone: _____

_____
Street Apartment#

_____
City State Zip Code

Secondary Insurance Plan Information (if applicable):

Name of Insured:_____ Relationship to Patient ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other
Last First MI

Insurers Birth Date: _____ Subscriber ID: _____ Group#: _____

Insured's Address: _____
Street Apartment#

_____
City State Zip Code

Employers Name: _____

Insurance Plan Name, Address and Phone: _____

_____
Street Apartment#

_____
City State Zip Code

Consent For Services

(Please read this section carefully and sign the bottom)

I voluntarily and knowingly request and consent to services, treatments and/or procedures recommended by McMillan Sedation Dentistry and to all diagnostic methods deemed appropriate by McMillan Sedation Dentistry, which may include, but not limited to, x-rays, study models, imagery and other aids. I authorize McMillan Sedation Dentistry to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that McMillan Sedation Dentistry may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of services, treatments, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by McMillan Sedation Dentistry. I acknowledge that any insurance coverage that I may have is based on a contract between my insurance company and me, my spouse and/my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge I am fully responsible for the payment of all sums owed to McMillan Sedation Dentistry for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, McMillan Sedation Dentistry will bill my insurance company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company for any reason (including but not limited to the insurance company declining coverage after initially approving it) or if the insurance company fails for any reason to reimburse the dentist within 30 days after being billed by McMillan Sedation Dentistry. I acknowledge that it is my responsibility to provide McMillan Sedation Dentistry with my current insurance information and any changes thereto.

I understand that if, for any reason other than traumatic accident or patient non-compliance, my restorations fail or break, they will be replaced by the dental office of McMillan Sedation Dentistry for laboratory fees for the first two years following the permanent placement. I understand that the warranty work ***must*** be performed by the office of McMillan Sedation Dentistry in order to comply with the terms of my warranty. After the completion of the first full two years following the initial treatment, I will be responsible for sixty percent (60%) of the current replacement fee, eighty percent (80%) after three full years and the total cost (100%) after 5 complete years.

I understand that in order to initiate my warranty, it is my responsibility to complete all recommended restorative treatment and follow recommended maintenance schedules, including and not limited to hygiene appointments, post-operative home care, post-op appointments, delivery of permanent restorations and prosthetics, and custom occlusal guard protection and that this treatment must be performed at the dental office of McMillan Sedation Dentistry. If my treatment and maintenance plans are not followed as recommended, and/or appointments are missed, adverse results could affect my dental health and insurance coverage. If I do not proceed with my recommended treatment plan in a timely manner, I understand that I could risk requiring further treatment for the involved teeth, supportive tissues, adjacent and opposing teeth, and/or muscles or joints; and upon such circumstance, any warranty may be revoked at the doctor's sole discretion.

I understand that this office reserves the right to charge a cancellation fee of $75 per hour in the event that I fail to appear and/or give ***2 full business days*** **notice** to reschedule or cancel any **hygiene appointment**. I understand that this office reserves the right to charge a cancellation fee of $150 per hour in the event that I fail to appear and/or give ***2 full business days*** **notice** to reschedule or cancel any **appointment with Dr. McMillan**. Exceptions will be made at the doctor's sole discretion for circumstances related to or involving true medical emergency or death in the family. I further understand that my cancellation fee must be paid prior to scheduling any additional or future appointments on my or my family's behalf. This office will make every reasonable effort to remind me of my scheduled appointments; however, I agree and understand that it is my responsibility to remember and attend my appointments.

I understand that fee estimates can only be extended for a period of 30 days from the date of the patient examination.

I consent to McMillan Sedation Dentistry's use and disclosure of my health information to my insurance company and any agent thereof. I hereby assign to the dentist all of the insurance benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company to make payment directly to McMillan Sedation Dentistry for the costs associated therewith.

Consent For Services (continued)

(Please read this section carefully and sign the bottom)

I understand that this office complies with the Health Insurance Portability and Accountability Act (HIPAA). A full explanation is available for me at the front desk should I require more information.

I grant my permission to you or your assignee, to telephone, mail, or e-mail me at any/all of the contact information listed above to discuss matters related to this form and or my patient care. I further consent to be contacted by McMillan Sedation Dentistry, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to McMillan Sedation Dentistry and/or by facsimile, email, or phone number (whether a cell phone or landline) at any facsimile number, email address, or phone number.

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

Patient Signature: _____ Date: _____

Print Name: _____

Guardian/Responsible Party (if Minor):_____

Print Name: _____ Date: _____

Medical Information Release Form/Designation of Personal Representative

(HIPAA Release From)

You may designate a personal representative who may act in your behalf of making decisions relating to health care, which includes treatment and payment issues. This individual can be a family member, a friend, lawyer or unrelated party.

Please print neatly to ensure correct and prompt processing. We reserve the right to return illegible or incomplete forms.

- ☐ I authorize the release of information including diagnosis, records, examinations rendered to me and claims and payment information. This information may be released to:
  - ☐ Spouse: _____
  - ☐ Child(ren):_____
  - ☐ Other:_____

Messages

To best reach me please call: ☐ Home ☐ my work ☐ my cell phone

If unable to reach me:

- ☐ you may leave a detailed mssage
- ☐ please leave a message asking me to return your call
- ☐ _____

The best time to reach me is: _____

Signed: _____ Date: _____