Michelle McClintock DDS PA
Cosmetic, Implant and Family Dentistry

New Patient Information

Please complete all fields. If any item does not apply, please write N/A.

Patient Full Name:_____

Age:_____ Date of Birth:_____ Sex:_____

SSN:_____ Marital Status:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Home #_____ Cell #_____

Email:_____

Patient's Employer: _____ Work #_____

Primary Doctor's Name:_____ Phone# _____

Complete ONLY if patient is a minor or student

Mother's Name:_____
SSN:_____ DOB:_____
Employer:_____
Work # _____

Father's Name: _____
SSN:_____ DOB:_____
Employer:_____
Work # _____

Emergency Contact

Name:_____ Phone:_____

Primary Insurance

Insurance Company's Name: _____

Policy Holder's Name: _____

Employer: ____

SSN: ________________________________ DOB: _____________________________

APPLICATION FOR DENTAL TREATMENT

TREATMENT
I hereby apply for acceptance as a patient of **Dr. Michelle McClintock** or **Dr. Margaret Bradley**.
I am aware that dental treatment will be rendered by licensed dentists and/or hygienists..

I understand that my treatment will be provided according to the availability of the practitioner.

APPOINTMENTS
I understand that if I fail to pay fees, keep appointments, or cancel appointments less than 24 hours before their scheduled times, I may be charged a $35 cancellation fee and could be dismissed as a patient.

RECORDS/ TEST/ PROCEDURES
I will make known any diseases, allergies, or unusual reactions to drugs or medicines that have occurred to me in the past. If my health or medications change, I will inform the Doctor/Hygienist at my next appointment without fail. I understand that if, during the course of my treatment in this facility, a dentist, hygienist, or employee has an accidental exposure to my blood, a specimen of my blood may be requested and tested for the presence of blood borne diseases. I understand that I may refuse such a blood test and it will not affect my status as a patient. The tests may be done at no charge and will not imply that I carry a disease or am at high risk. The results of such tests or exposure will remain confidential and will not become a part of my permanent record. I will consent to the use of photographs, X-ray films, impressions, and other laboratory diagnostic tests where they are indicated for the purpose of diagnosing and planning treatment. I consent to the use of local anesthetic and other methods of pain control to make me more comfortable while receiving dental treatment.

I understand that unless otherwise arranged, payment for professional service is required on the day the treatment is rendered.

I understand that all original dental records, X-ray films, and diagnostic aids are the property of Dr. Michelle McClintock and cannot be taken, or sent, from Dr. Michelle McClintock. Copies will be provided upon request of a dentist or physician.

This is to certify that to the best of my knowledge all the preceding answers are true and correct and that I, the undersigned, consent to the performing of any and all dental and oral surgery procedures diagnosed as necessary or advisable by Dr. Michelle McClintock and staff, and I will assume responsibility for fees associated with those procedures.

SIGNATURES

_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PERSON (AGE 19 OR OLDER) DATE SIGNED (M/D/Y)

_____
PRINTED NAME OF PATIENT

_____
SIGNATURE OF WITNESS

Dental Insurance & Our Office

As a benefit to our patients, we gladly file your insurance on the day of your appointment. Our fees are reflective of the standard of care we provide. We understand, in today's economy, that extra money is a little harder to come by, so we are extremely thankful for all of our patients who continue to come to our office as an out-of-network provider. Because we are out-of-network, we are not contracted with your insurance company and cannot make any guarantees as to what they will or will not pay.

Our contract is with you, our patient, and we will always respect that relationship. We will provide the best care possible and will continue to be here for you and your family.

Our patients, on the other hand, have two contracts. If you have insurance, you have a contract with the insurance company: you pay your premiums and they pay benefits. You, also, have a contract with our office: we provide a service for a fee and you pay the fee. There is no contract between our office and your insurance company. Your insurance is like a gift card that you can apply towards our fees- the gift card has exclusions and a maximum value. As health care providers, we cannot base your treatment on your "gift card"; we base it on your needs. Dr. McClintock does not enter into contracts with insurance companies, because she is dedicated to your health not the insurance company's bottom line. Because of our out-of-network status, there will be times when there is a difference in what we charge and what your "gift card" pays. That difference is your out of pocket expense that we believe is worth the care we provide. We are not here to only provide "gift card" dental health.

We are dedicated to providing you the best oral healthcare we possibly can. Dr. McClintock makes recommendations based on over 20 years of clinical experience and countless hours of continuing education. Our team follows her philosophy.

I have read and understand the statements above.

Signature: _____ Date: _____

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only

Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

Height:

For Office Use Only
BP Heart Rate:

Weight:

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)