*Welcome To…*

# Dr. Rob McArthur's Office

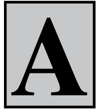
*Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.*

***(For Office Use Only)***

Patient Chart #________________

Today's Date ________________

Referred By ________________



## Adult Patient Information (CONFIDENTIAL)

Name ____________________ Preferred Name ____________________ Age ____________

Sex: M F Race____________________ Date of Birth ____________________ SS# ______ - ______ - ______

Address ______________________________________________

Street City State Zip

Home Phone ____________________ Cell Phone ____________________ Work Phone ____________________

Best Phone # to Confirm Your Appointment ____________ Your Occupation ____________ Where Employed ____________

Your E-mail Address: ______________________________________________

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

If Student, Name of School/College ____________________ City____________ State___ Full-Time__ Part-Time__

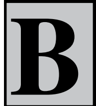
Spouse's Full Name ____________________ Date of Birth ____________ SS# ______ - ______ - ______ Cell Phone ____________

Occupation ____________________ Employer ____________________ Work Phone ____________________

Children's Names and Ages ______________________________________________

In Case of Emergency, who may we contact? ____________________ Phone # ____________________

## Insurance Information - Please Present Card



## Adult Medical History

*Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.*

Medical Doctor's Name ____________________ Office Phone ____________________ Date of Last Exam________________

Office Location: ______________________________________________

Street City State Zip

| | Yes | No |
|---|---|---|
| **1. Are you under medical treatment now?** | ❑ | ❑ |
| **2. Have you ever been hospitalized for any surgical operations or serious illness within the last 5 years?** If yes, please explain ____________________ | ❑ | ❑ |
| **3. Are you taking any over the counter medicines presently? (Aspirin, Tylenol, Herbs, Supplements, Vitamins)** If yes, what medication(s) are you taking? ____________________ | ❑ | ❑ |
| **4. Do you use tobacco products?** | ❑ | ❑ |
| **5. Do you use controlled substances / narcotics?** | ❑ | ❑ |

**6. Alcohol Consumption:** ❑ Never ❑ Occasional ❑ Moderate

| | Yes | No |
|---|---|---|
| **7. Are you taking medication for osteoporosis?(Actonel®, Fosamax®, Boniva®.** | ❑ | ❑ |

**8. Are you allergic to or have you had any reactions to the following?**

| | Yes | No |
|---|---|---|
| Local Anesthetics (e.g. Novocaine) | ❑ | ❑ |
| Penicillin or any other Antibiotics | ❑ | ❑ |
| Sulfa Drugs | ❑ | ❑ |
| Barbiturates, Sedatives, or Sleeping Pills | ❑ | ❑ |
| Iodine | ❑ | ❑ |
| Aspirin | ❑ | ❑ |
| Any Metals (e.g. nickel, mercury, etc.) | ❑ | ❑ |
| Latex Rubber | ❑ | ❑ |

Other (please list)____________________

**9. Women Only:**

| | Yes | No |
|---|---|---|
| a) Are you pregnant or think you may be pregnant? | ❑ | ❑ |
| b) Are you nursing? | ❑ | ❑ |
| c) Are you taking oral contraceptives / birth control? | ❑ | ❑ |
| d) Hormone Replacement | ❑ | ❑ |

e) Other ____________________

| | Yes | No |
|---|---|---|
| **10. Have you ever or are you scheduled to begin treatment with intra venous bisphosphonates (Aredia, Zometa, Reclast) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?** | ❑ | ❑ |

Date treatment began: ____________________

***Over Please***

PATIENT NAME ______________________ BIRTHDATE ________________ TODAY'S DATE __________

***11. Do you have or have you had any of the following? Please list any medications you are taking for this condition.***

- ❑ *Heart Attack* ❑ *Heart Bypass Surgery* *Year?*__________ *Meds:* __________
- ❑ *Heart Disease* ❑ *Heart Murmurs* ❑ *Mitral Valve Prolapse* __________ *Meds:* __________
- ❑ *Angina* *Do you take nitroglycerin tablets?*__________ *Meds:* __________
- ❑ *Rheumatic* ❑ *Scarlet Fever* __________ *Meds:* __________
- ❑ *Joint Replacement* *Type:*__________*Where:*__________ *Meds:* __________
- ❑ *Heart Pacemaker* *Date Placed?*__________ *Meds:* __________
- ❑ *Blood Pressure Problems:* ❑ *HIGH* ❑ *LOW* __________ *Meds:* __________
- ❑ *High Cholesterol* __________ *Meds:* __________
- ❑ *Blood Clotting Problem* ❑ *Hemophilia* ❑ *Aspirin/Coumadin Therapy* ___ *Meds:* __________
- ❑ *Diabetes* ❑ *Type I* ❑ *Type II* ❑ *Insulin* ❑ *Oral Medications* _______ *Meds:* __________
- ❑ *Asthma* ❑ *Allergies* ❑ *Hay Fever* ❑ *Sinus Trouble* __________ *Meds:* __________
- ❑ *Convulsions* ❑ *Epilepsy* ❑ *Fainting Problems* __________ *Meds:* __________
- ❑ *Cancer* *Type:*__________ *Year?*__________ *Meds:* __________
- ❑ *Radiation / Chemotherapy: Where?*__________*Year?*__________ *Meds:* __________
- ❑ *Anemia: Sickle Cell / Pernicious / or Blood Diseases* __________ *Meds:* __________
- ❑ *Lung or Respiratory Problems* ❑ *Emphysema* ❑ *Tuberculosis* *Year?*____ *Meds:* __________
- ❑ *Thyroid* ❑ *Parathyroid Disease* __________ *Meds:* __________
- ❑ *Hepatitis* ❑ *Liver Disease* ❑ *Jaundice* *Type:*__________ *Year?*___ *Meds:* __________
- ❑ *Kidney* ❑ *Bladder* ❑ *Prostate Problems* __________ *Meds:* __________
- ❑ *AIDS* ❑ *HIV Infection* ❑ *Sexually Transmitted Diseases* __________ *Meds:* __________
- ❑ *Arthritis* ❑ *Rheumatism* __________ *Meds:* __________
- ❑ *Stroke* ❑ *Migraine Headaches* ❑ *Brain Injury* ❑ *Nervous Disorder* ___ *Meds:* __________
- ❑ *Stomach Troubles* ❑ *Ulcers* ❑ *Acid Reflux* ❑ *Other*__________ *Meds:* __________
- ❑ *Eye Disease* ❑ *Glaucoma* ❑ *Contact Lens* ❑ *Lens Implants* __________ *Meds:* __________
- ❑ *ADHD* ❑ *ADD* __________ *Meds:* __________
- ❑ *Skeletal Problems* ❑ *Injuries* __________ *Meds:* __________
- ❑ *Hearing Loss* ❑ *Ear Problems* __________ *Meds:* __________
- ❑ *Muscular Diseases* ❑ *Chronic Fibromyalgia* __________ *Meds:* __________
- ❑ *Genetic Diseases (ex. Cystic Fibrosis)* __________ *Meds:* __________
- ❑ *Emotional/Psychiatric Care* __________ *Meds:* __________
- ❑ *Blood Transfusion DATE* _______ ❑ *Hemophilia* __________ *Meds:* __________
- ❑ *Other:*__________

***For Office Use Only:*** ***SBE Coverage Needed*** ❑ ***Yes*** ***Use:*** ❑ ***Amoxicillin*** ❑ ***Keflex*** ❑ ***Clindamycin*** ❑ ***Other*** __________

## C Medical History Update

**Please review section C of your medical history and make any changes needed. Please list any new medical diagnosis/treatment or medications that have been prescribed by your medical doctor since your last visit.** *Please include any additional medical doctor's name, address and office telephone number. Thank you!*

| DATE | CHANGES / NEW MEDS / COMMENTS | DATE | CHANGES / NEW MEDS / COMMENTS |
|---|---|---|---|
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# Family Practice Dentistry
***Robert E. McArthur, DDS, PA***

## OFFICE POLICIES

We appreciate you allowing us to provide dental care for you and your family. We value our relationship and believe the best relationships are those based on understanding.

### Payment

Our staff believes that **ALL** financial arrangements should be completed **BEFORE** treatment appointments are scheduled. For your convenience we offer the following payment methods to serve as a guide for making financial arrangements.

- Payment is expected at the time services are rendered. We gladly accept payment by cash, check, or credit/debit card (including CareCredit)
- Dental insurance – A copy of your dental insurance card is required. As a courtesy, we will file your insurance and accept payment from them. However, most dental insurance do not cover 100% of the cost of treatment. Because of this and the long delay in receiving payment from the insurance company, you will be asked to pay your **estimated** portion the day dental service is rendered. Your insurance will pay according to what they consider to be "usual & customary"; therefore, your portion due at the time services are rendered is AN ESTIMATE. We will assist you in dealing with your insurance company, but **the ultimate responsibility of payment of services rendered is with you**. **Please understand your policy is a contract between you, your employer and the insurance company. It is your responsibility to inform us of any changes to your insurance policy. *After 60 days* the balance will be due in full by you**.

  **NOTE:** Some insurance companies will send the insurance payment to you. To keep us from asking you to pay the total amount up front, we ask you to PROMPTLY forward the insurance payment you receive to us along with explanation of benefits (EOB).

***In case of account default, the responsible party is liable for any/all collection fees and/or attorney fees associated.***

### Appointments

To better serve all our patients, we seek to follow a regular time schedule. We respect our patients' valuable time and try to make all efforts to limit your waiting to an absolute minimum. **We expect you to notify our office as soon as possible if you are unable to keep your schedule appointment. A fee of $50.00 will be billed for repeated broken appointments.**

*By signing below, I understand I am the responsible party and agree I have read and understand the policies stated above. I agree to comply as long as I remain a patient of this practice.*

_______________________________________ *Responsible Party Signature* _______________ *Date*

### Notice of Privacy Practices

I, ________________________________, have received a copy of the office's Notice of Privacy Practices. I also agree to keep confidential any health information that I may see and/or hear from incidental and/or non-incidental source. I also give Dr. McArthur's office permission to release any information concerning my medical/dental information to insurance companies, other medical/dental offices as well as my family members indicated: ______________________.

_______________________________________ *Signature* _______________ *Date*

***For Office Use Only***

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

_____ Individual refused to sign _____ Communication barrier _____ Emergency situation _____Other: ____________________

# Robert E. McArthur, D.D.S.,P.A.

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**
**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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**OUR LEGAL DUTY**
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect immediately, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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**USES AND DISCLOSURES OF HEALTH INFORMATION**
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.