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 _____

A Child Patient Information (CONFIDENTIAL)

Child's Full Name _____ *Preferred Name* _____ *Age* _____

Sex: M F Race _____ *Date of Birth* _____ *SS#* _____ - _____ - _____

Child Resides With _____ *Relationship to Child* _____

Phone Numbers for Confirmation of Appointment _____ *Cell Phone* _____

Patient's Address: _____ *Home Phone* _____
Street City State Zip

Father's Name _____ *Date of Birth* _____ *SS#* _____ - _____ - _____

His Address _____ *Home Phone* _____
Street City State Zip

Where Employed: _____ *Occupation:* _____ *Work Phone* _____

Mother's Name _____ *Date of Birth* _____ *SS#* _____ - _____ - _____

Her Address _____ *Home Phone* _____
Street City State Zip

Where Employed: _____ *Occupation:* _____ *Work Phone* _____

Responsible Party (If Different From Above)

Name of Person Responsible for this Account _____ *Relationship to Patient* _____

Address _____
Street City State Zip

Home Phone _____ *Cell Phone* _____ *E-mail Address* _____

Driver's License # _____ *Date of Birth* _____ *SS#* _____ - _____ - _____

Where Employed _____ *Occupation* _____ *Work Phone* _____

Is this Person Currently a Patient in our office? ❑ *Yes* ❑ *No*

Insurance Information

Name of Insured _____ *Relationship to Patient* _____

Birthdate _____ *SS#* _____ - _____ - _____

Name of Employer _____ *Work Phone* _____

Insurance Company _____ *Group #* _____ *Policy ID #* _____

Ins. Co. Address _____
Street City State Zip

B Child Medical History

Although dental personnel primarily treat the area in and around the mouth, your child's mouth is a part of his/her entire body. Health problems that he/she may have, or medication that they may be taking, could have an important interrelationship with the dentistry that they 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*

HEALTH HISTORY

Yes	*No*	***Child's weight*** _____
❑	❑	*Is your Child in good health?*
❑	❑	*Is your Child up to date with immunizations?*
❑	❑	*Is your Child presently taking medicine?*
		If so, what? _____
❑	❑	*Has your Child experienced any unfavorable reaction to medicine?*
❑	❑	*Is your Child presently undergoing medical treatment?*
		If so, what? _____
❑	❑	*Has your Child been hospitalized since birth?*
		Date _____ *Reason* _____
❑	❑	*Does your Child have any infectious diseases?*
		If yes, list. _____

Yes	*No*	***Has your Child experienced:***
❑	❑	*Chronic cough?*
❑	❑	*Night Sweats?*
❑	❑	*Chronic Fatigue?*
❑	❑	*Recurrent Mouth Sores?*
		Has your Child ever had:
❑	❑	*Blood transfusions?*
❑	❑	*Chemotherapy?*
❑	❑	*Transplant surgery?*

Check any of the following that may pertain to you.

❑ *Heart Condition*	❑ *Tuberculosis*
❑ *Heart Murmur*	❑ *Asthma*
❑ *Lung Problem*	❑ *Allergies*
❑ *Brain Injury*	❑ *Retardation*
❑ *Liver Problem*	❑ *Muscle Disorder*
❑ *Kidney Problem*	❑ *Emotional Disorder*
❑ *Epilepsy*	❑ *Nervous Disorder*
❑ *Diabetes*	❑ *Autism*
❑ *Cerebral Palsy*	❑ *Speech Disorder*
❑ *Bleeding Disorder*	❑ *Hearing Disorder*
❑ *Sickle Cell Anemia*	❑ *Vision Disorder*
❑ *Hepatitis*	❑ *Other*
❑ *ADHD / ADD*	

What is your water source? ❑ **Private Well** ❑ **Public System** ❑ **Name of System** _____

Yes	*No*	
❑	❑	*Is this your Child's first dental visit?*
		If not, date of last dental care: _____
❑	❑	*Has your child had an unfavorable experience in a dentist office?*
❑	❑	*Does your child have a toothache?*
		Purpose of appointment: _____

Yes	*No*	
❑	❑	*Is your Child a finger sucker?*
❑	❑	*Does your child use a pacifier?*
❑	❑	*Was your child bottle fed?*
		Age discontinued: _____
❑	❑	*Was your child breast fed?*
		Age discontinued: _____

Thank you for your help. If there is any information that you can think may be of value to us in treating your child, please feel free to comment:

_____

I agree to diagnostic procedures and dental treatments as found necessary by Robert E. McArthur, DDS for the patient named above. I will accept responsibility for this account or any part thereof should responsible party fail or insurance benefit be denied or insufficient to pay the full bill.
Signature of responsibility party: _____ Date _____
_____ Dental assistant reviewing history prior to doctor's review of history.

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

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.

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.

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.