Medical Information

1. Are you having pain or discomfort at this time? .... YES NO
2. Have you been a patient in the hospital during the past two years? .... YES NO
3. Have you been under the care of a medical doctor during the past two years?............. YES NO
   Physician's Name ________________________ Phone No. __________________
   Reason ____
4. Are you now taking any medication or drugs?.. YES NO
   If yes, please list: ____
5. Are you sensitive or allergic to any medication or anesthetics? .... YES NO
   If yes, please list: ____
6. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Disease or Attack............	YES	NO	Emphysema	YES	NO
Angina Pectoris..........................	YES	NO	Tuberculosis	YES	NO
Heart Murmur	YES	NO	Asthma	YES	NO
High Blood Pressure..................	YES	NO	Allergies or Hives.....................	YES	NO
Mitral Valve Prolapse	YES	NO	Sinus Trouble...........................	YES	NO
Artificial Heart Valve	YES	NO	Hepatitis A, B, or C	YES	NO
Heart Pacemaker.......................	YES	NO	Latex Allergy............................	YES	NO
Rheumatic Fever........................	YES	NO	Venereal Disease	YES	NO
Cortisone Medicine....................	YES	NO	H.I.V. Positive or AIDS	YES	NO
Drug Addiction	YES	NO	Anemia	YES	NO
Stroke	YES	NO	Liver Disease...........................	YES	NO
Artificial Joints (hip, knee, etc.) ..	YES	NO	Epilepsy or Seizures................	YES	NO
Kidney Trouble	YES	NO	Fainting or Dizzy Spells	YES	NO
Diabetes....................................	YES	NO	Anxiety.....................................	YES	NO
Cancer	YES	NO	Tobacco / Alcohol Use	YES	NO

7. Have you lost or gained more than 10 pounds in the past year?........................ YES NO
8. Are you on a special diet?........... YES NO   Ever taken Fen-Phen .... YES NO
9. Do you have any disease or condition not listed? Have you ever taken a bone-producing medication (bisphosphonates)? .... YES NO
   If yes, please list: ____

FOR WOMEN ONLY:

Are you pregnant? ( ) YES, What month? ______ ( ) NO. Are you nursing? ( ) YES ( ) NO

Are you taking birth control pills? ( ) YES ( ) NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature________________________________ Date____________________

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)______________________________. I understand that using anesthetic agents embodies a certain risk.
   Furthermore, I authorize and consent that doctor choose and employ such anesthetic as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.83% APR may be added to my account.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient ______________________________________ Date ___________ Witness __________________

Parent or Responsible Party______________________ Relationship to Patient__________________

FOR OFFICE USE: Review ______________________ DATE _______________

Patient Information

Date______________

Patient's Name ____
Last First Middle

Address ____
Street City State Zip

Home Phone __________________ Cell Phone __________________ Work Phone ______________

Birthdate __________________ Social Security #________________ Drivers License #______________

E-Mail:____

If patient is a minor, give parent's or guardian's name ____
Whom may we thank for referring you to our office? ____
Name of nearest relative not living with you ____
Complete Address ____ Phone ______________

Responsible Party Information

Name ____
Last First Middle

Address ____
Street City State Zip

Mailing Address ____
Street City State Zip

How long at this address_______________

Previous Address (if less than 3 years) ____

Home Phone __________________ Cell Phone __________________ Work Phone ______________

Social Security #_______________ Birthdate _____________ Relationship to patient ______________

Employer ____________________ Occupation ______________________ No. Years Employed________

Employer Address ____

Spouse's Name ______________________________________ Relationship to patient______________

Employer ____________________ Occupation ______________________ No. Years Employed________

Social Security #_______________ Birthdate__________________ Work Phone______________

Insurance Information

Insured's Name_____________________________ Insured's Social Security #__________________

Insurance Company______________________________ Group No. __________________

Insurance Co. Address ______________________________ Phone # __________________

Is policy connected with your union? Yes ___ No ___ (If yes: Please complete the following insurance information)

Insured's Name_____________________________ Insured's Social Security #__________________

Insurance Co. ______________________ Group No. _________________ Local No. ______________

Insurance Co. Address ______________________________ Phone #__________________

Insured's Employer______________________________ Phone #__________________

Dental Information

Do your gums bleed when you brush? Yes __ No __

Are your teeth sensitive to heat or cold? Yes __ No __ Pressure? Yes __ No __ Sweets? Yes __ No __

Do you grind or clench your teeth? Yes __ No __

Do you have any fear of dental work? Yes __ No __

Date of last dental examination ________________ What was done at that time?__________________
____

How would you describe your current dental problem?____
____

How do you feel about the appearance of your teeth? ____

Have you ever had orthodontic braces?____

Curtis E. McRae, D.D.S., Inc.
General/Cosmetic/Implant Dentistry

Assignment of Benefits Agreement

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this form and/or other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- It is your responsibility to pay the copayment, which is the amount not covered by your insurance company, at the time we provide service to you.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our office. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with regulations and the requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO CURTIS E. McRAE, D.D.S., INC.

I AUTHORIZE CURTIS E. McRAE, D.D.S., INC. TO DEBIT MY CREDIT CARD IF PAYMENT FROM MY INSURANCE COMPANY HAS NOT BEEN RECEIVED WITHIN 60 DAYS OF RECEIVING TREATMENT.

______________ ______________ ______________ ______________

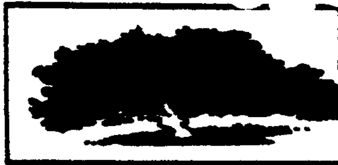
Print Name | Credit Card Number | Expiration | V-code (3 digits on back)

______________ ______________

Signature of Patient/Responsible Party | Date

3601 Vista Way, Suite 205 • Oceanside, CA 92056 • (760) 757-5057

POS Reorder # 1525375



Curtis E. McRae, D.D.S., Inc.
General/Cosmetic/Implant Dentistry

Financial Policy

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality dental care using only the best materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate service to you while minimizing our administrative costs.

All charges that incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you, we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file your insurance claim, you must bring a completed dental insurance form or proof of insurance to our office.

Payment is due at the time of service provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available through CareCredit upon request and approval.

Returned checks and balances older than 60 days must be subject to collection fees and finance charges at the rate of 1.83% per month. Additionally, our office may charge you for broken appointments and appointments cancelled without 48-hour advance notice.

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

____
Print Name

______________________________ ________________
Signature Date

3601 Vista Way, Suite 205 • Oceanside, CA 92056 • (760) 757-5057