MAC DENTAL
Family Focused Dentistry

Patient Information

All information is confidential

Patient First Name:________________M.I.________ Last Name:________________Preferred Name: ___________

Address:________________________City:____________________State:___________Zip: _______________

Cell Phone: ________________ Home Phone: _________________May we send you text messages? (Circle) Yes No

Email Address: ____________________________ Preferred Method of Contact: ____________________________

Birth Date: ________________ Sex: (Circle) Male Female S.S. #: __________________________

Employer:________________________________ Work Phone: ______________________________________

How did you hear about us? (Please circle only one): Insurance List, Mailer, Google/Bing/Yahoo/Yelp, Billboard,

Facebook, Friend/ Relative (Name):____other: _______________________

Marital Status: (Circle) Minor / Single / Married / Divorced / Widowed / Engaged / Domestic Partnership

Spouse's Info. Name: ____________________Phone #:_______________SS#:_____________DOB:______________

May we share your protected health information, account information and link information with your spouse?

(Circle) **Yes** **No**

Parent, Guardian or Emergency Contact Information:

First Name: ________________M. I. ______ Last Name: _________________Relationship to Patient: ___________

Cell Phone: _______________ Home Phone: _______________ Email: ____________________________________

Address: __________________City:___________________ State: _______________ Zip: ______________

Employer: _____________________________ Work Phone: ____________________________

May we share your protected health information with this person? (Circle) **Yes** **No**

May we share your account information with this person? (Circle) **Yes** **No**

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*I understand that by signing below I am financially responsible for the patient listed at the top of this form and that I have read and understand the *Payment/ Co-pay section on page two of this form.*

X____**Date:** ____________________

Dental History:	**Yes**	**No**	**Unknown**
Have you ever had a full-mouth series of x-rays or an x-ray that went all around your head (panoramic x-ray)? If yes, how long ago? ______________________________			
Do you experience jaw popping or clicking or pain in your jaw?			
Do you grind your teeth? If yes, circle: While sleeping / While awake			
Have you ever had trouble getting numb?			
Have you ever had an allergic or adverse reaction to dental anesthetic?			
Do you have anxiety/ fear of the dentist/ dental office?			
Do you prefer to have nitrous oxide (laughing gas) during your procedure?			
Do you have any esthetic concerns about your mouth? (Bleaching, Veneers, Invisalign, etc)			
Would you like to improve your smile?			
Have you participated in sleep study or been advised to use a CPAP?	Do you snore?		
Please tell us anything else you feel is important to your dental care:			
Denture/ Partial Patients:			
Approximately how old is your current denture/ partial?			
What complaints, if any, do you have with your current denture/ partial?			

Consent- I give my consent to be seen by the doctor. If I elect treatment, I consent for the work to be done. I understand that during the course of the procedure(s) unforeseen conditions may arise which necessitate procedures other than contemplated. I am aware there may be additional charges associated with the new treatment. I understand that the treatment plan/options I was given is just an estimation and the actual amount of my treatment could differ from the amount originally quoted. I trust that the doctor has given me the closest possible estimation and I will be informed of any additional costs that are incurred.

HIPAA- I have reviewed and acknowledged the Notice of Privacy Practices for the office and consent for use and disclosure of health information. I have notated on page one of this form whether or not the office may share my protected health information and account information with my spouse (if applicable) and one other person I have listed. I understand if I wish for the office to share my protected health or account information with anyone other than my spouse or the other person I have listed on page one, I will need to complete and sign a separate form. Please see additional paper work available to all our patients.

I have read and completed all items in good faith and as accurately as possible. I understand this form will remain effective until a new "Patient Information" form is completed and signed for the patient listed on page one.

Patient/Guardian Signature____**Date** _____________

Thank you for choosing to join our dental family. We would love to meet the rest of your family and friends. Please be sure to share with them your experience here at Mac Dental.

Sincerely,

Your Mac Dental Team