McGlone Dental Care
Gregory McGlone, DMD
Acknowledgement of Receipt of Notice of Privacy Practices (NPP) HIPAA

You May Refuse to sign this Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of out Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify)

_____

_____

_____

_____

McGlone Dental Care – Gregory S. McGlone, DMD Date: _____

HOW DO YOU WANT TO BE ADDRESSED when summoned in the reception area:

□First name only □Surname □Other: _____

PATIENT AUTHORIZATION FOR INFORMATION CONVEYANCE

PLEASE LIST OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (e.g., step parents, grandparents, caregivers)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT AND BILLING INFORMATION** VIA:

□Cell Phone □Home Phone □Work Phone □Email Confirmation

□Text Message to Cell Phone □**Any of The Above**

I AUTHORIZE **MY HEALTH INFORMATION** BE CONVEYED VIA:

□Cell Phone □Home Phone □Work Phone □Email Confirmation

□Text Message to Cell Phone □**Any of The Above**

I APPROVE BEING CONTACTED ABOUT SPECIAL **SERVICES, EVENTS, FUND RAISING EFFORTS, OR NEW HEALTH INFO** ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

□Voice Message □Text Message □Email

□**Any of the above** □**None of the above (Opt Out)**

In signing this HIPAA Patient Authorization Form, you acknowledge and authorize that this office may recommend products or services to promote your improved heath. This office may or may not receive third-party remuneration from these affiliated companies. We, under current HIPAA 2.10-11 rules, provide you this information with your knowledge and consent.

MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION (PHI) DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE. A copy of this signed, dated document shall be as effective as the original.

_____ _____

Please PRINT your name Please SIGN your name

_____ _____

Legal Representative Conveyance Description of Authority

Patient Medical History

McGlone Dental Care – Gregory S. McGlone, DMD

Patient's Name (Print)_____

Although dental personnel primarily treat the are 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 you will receive. Thank you for answering the following questions.

Are you under a physician's care now? □Yes □No □N/A _____

Have you ever been hospitalized or had a major operation? □Yes □No □N/A _____

Have you ever had a serious head or neck injury? □Yes □No □N/A _____

Are you taking and medication, pills, or prescription drugs? □Yes □No □N/A _____

If yes, please list medications: _____

Are you on a special diet? □Yes □No □N/A _____

Are you allergic to and of the following? □Aspirin □Penicillin □Codeine □Sulfa

□Acrylic □Metal Latex □Local Anesthetics □Other (Please Specify) _____

Women: Are you □Pregnant/Trying to become pregnant □Nursing □Taking Oral Contraceptives

Do you have, or have you ever had, any of the following:

□Aids/HIV Positive	□Cancer	□Fainting Spells/Dizziness	□Intestinal/Stomach Disease	□Rheumatism
□Alzheimer's Disease	□Chemotherapy	□Frequent Cough	□Irregular Heartbeat	□Scarlet Fever*
□Anaphylaxis	□Chest Pains	□Frequent Headaches	□Kidney Problems	□Shingles
□Anemia	□Cold Sores/Fever Blisters	□Heart Attack/Failure	□Leukemia	□Sickle Cell Disease
□Angina	□Congenital Heart Disorder	□Heart Murmur*	□Liver Disease	□Sinus Trouble
□Arthritis/Gout	□Cortisone Medicine	□Heart Pace Maker*	□Low Blood Pressure	□Stroke
□Artificial Heart Valve*	□Diabetes	□Heart Trouble/Disease	□Lung Disease	□Swelling of Limbs
□Artificial Joint*	□Drug Addiction	□Hemophilia	□Mitral Valve Prolapse*	□Thyroid Disease
□Asthma	□Easily Winded	□Hepatitis A	□Pain in Jaw Joints	□Tonsillitis
□Blood Disease	□Emphysema	□Hepatitis B or C	□Parathyroid Disease	□Tuberculosis
□Blood Transfusion	□Epilepsy or Seizures	□High Blood Pressure	□Radiation Treatments	□Tumors or Growth
□Breathing Problem	□Excessive Bleeding	□Hives or Rash	□Renal Dialysis	□Ulcers
□Bruise Easily	□Excessive Thirst	□Hypoglycemia	□Rheumatic Fever*	□Yellow Jaundice

Have you ever had any serious illness not listed above? □Yes □No If yes please specify:

_____

Comments: _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature: Date:

Patient Dental History

McGlone Dental Care – Gregory S. McGlone, DMD

Patient's Name (Print): _____

Do You Smoke or Use Chewing Tobacco? □No □Yes

How Much _____ How Long _____

Please Check Any of the Following Problems That Apply to You:

□Sensitivity (Hot, Cold, Sweet)	□Tooth Pain/Discomfort When Chewing	□Headaches, Earaches, Neck Pain	□Jaw Joint Pain
□Teeth or Fillings Breaking	□Grinding or Clenching Teeth	□Bleeding, Swollen or Irritated Gums	□Loose, Tipped or Shifting Teeth
□Bad Breath	□Bad Taste in Your Mouth		

Do You Have or Have You Ever Had Any of the Following:

□Dentures □Partial Denture □Braces □Periodontal (Gum) Treatments

If You Could Change Your Smile, You Would:

□Make It Brighter	□Make It Straighter	□Close Spaces	□ Have A Smile Makeover
□Repair Chipped Teeth	□Replace Missing Teeth	□Replace Old Crowns That Don't Match	□ Replace Metal Fillings with Tooth Colored Fillings

On A Scale of 1-10 With 10 Being The Highest Rating:

How Important Is Your Dental Health to You? 1 2 3 4 5 6 7 8 9 10

Where Would You Rate Your Current Dental Health? 1 2 3 4 5 6 7 8 9 10

Please Share the Following Dates:

Your last cleaning: _____/_____

Your last oral cancer screening: _____/_____

Your last complete x-rays: _____/_____

Why did you leave your previous dentist? _____

_____

Name of Previous Dentist:

City: State: Phone:

What is the most important thing to you about your dental visit? _____

_____

Patient Information Form

Welcome to McGlone Dental Care

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 of your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us.

Patient Information (Confidential) **Date:**

Name (Print): Birthdate:

Home Phone: Cell Phone:

Address: City: State/Zip:

Email: SSN:

Employer: Work Phone:

Business Address:

City: State/Zip:

Spouse or Parent/Guardian: Phone:

Spouse or Parent/Guardian Employer: Phone:

Whom may we thank for referring you?

Person not residing with you to contact in case of emergency:

Relationship: Phone:

Responsible Party

Name of person responsible for account:

Relationship to Patient State/Gov't ID#:

Address: Home Phone:

Email: Cell Phone:

Birthdate: SSN: Work Phone:

Employer:

Is this person a current patient: □Yes □No

Please list any minors or family members for whom this contact information applies.

For your convenience, we accept the following payment methods.
Cash, Check, Visa, MasterCard, Discover, American Express, & Care Credit.

Insurance Information

Name of Insured: Relationship to Patient:

Birthdate: SSN:

Employer: Work Phone:

Employer Address:

City: State/Zip:

Insurance Company:

Group #: ID #:

Insurance Address:

City: State/Zip:

Do you have secondary insurance? □No □Yes If Yes, complete the following:

Name of Insured: Relationship to Patient:

Birthdate: SSN:

Employer: Work Phone:

Employer Address:

City: State/Zip:

Insurance Company:

Group #: ID #:

Insurance Address:

City: State/Zip:

Cancellation Policy for McGlone Dental Care

Because of the level of service McGlone Dental Care provides our patients, your appointment is especially held just for you, so that we have the right amount of time for your procedure at our office.

We ask that you make every effort to give us at least a 24-hour notice if you cannot make your scheduled appointment. It is our policy to charge any patient for a broken appointment.

When patients do not show for their appointment or do not give us adequate cancellation notice, we are not given the opportunity to reschedule that time with another patient who has a true dental need.

If less than 24 hours' notice is given to cancel an appointment, a minimum $75.00 fee* will be assessed. In the event that no notice is given and the patient does not show up for their scheduled appointment, a minimum $100.00 fee* will be assessed.

Please note that insurance companies DO NOT cover fees for broken appointments, therefore payment is the patient's responsibility.

*Exceptions will be made on a case by case basis.

Please sign to acknowledge that you have read and understand MDC's cancellation policy.

_____ _____

Patient Signature Date