McAlpin Dental Group, P.A.

McAlpin Dental Group, P.A.
1563 Kingsley Avenue, Suite 107
Orange Park, FL 32073
904-269-1048 Phone
904-269-0109 Fax

Patient Information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient Name: _____ Date of Birth: _____ Sex: _____ Age: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Billing Address (if different): _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Driver's License #: _____ State: _____

SS#: _____ Employer/Occupation: _____ Work Phone: _____

Spouse's Name & Phone #: _____ Emergency Phone # (other than spouse): _____

Primary Dental Ins. Name: _____
Phone # ID # Group #

Secondary Dental Ins. Name: _____
Phone # ID # Group #

Subscriber's Name: _____ Date of Birth: _____ SS#: _____

Subscriber's Employer: _____

Name of Your Medical Doctor: _____ Date of Last Visit to Medical Doctor: _____

Name of Previous Dentist: _____ Date of Last Visit to Dentist: _____

Referred to Us By: _____

DENTAL HEALTH HISTORY

	YES	NO
Are you apprehensive about dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores in or about your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐

	YES	NO
How often do you brush? _____		
How often do you floss? _____		
Does your jaw make noise so that it bothers you or others?	☐	☐
Do you clench or grind your teeth frequently?	☐	☐
Does your jaw ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of your ears?	☐	☐
Do you have any jaw symptoms or headaches upon awaking in the morning?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	☐	☐
Do you have a temporomandibular (jaw) disorder (TMD)?	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐
Do you suffer from dry mouth?	☐	☐

MEDICAL HEALTH HISTORY Do you have, or have you had, any of the following?

	YES	NO
Heart Problems	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion?	☐	☐
Allergy Problems	☐	☐
Hay fever	☐	☐
Sinus Problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems	☐	☐
Ulcers/Acid reflux	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g., total hip or implants)	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Stroke(s)	☐	☐
Frequent or severe headaches	☐	☐
Thyroid Problems	☐	☐
Persistent cough or swollen glands	☐	☐
PREMEDICATIONS REQUIRED BY PHYSICIAN	☐	☐
Cancer/Tumor	☐	☐

Are you allergic, or have you reacted adversely, to any of the following?

	YES	NO
Local anesthetics ("Novocaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐
Other _____		

	YES	NO
Diabetes	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Alzheimer's, Dementia, Parkinsons or depression	☐	☐
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
Glaucoma/Vision Problems	☐	☐
Hearing Loss	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Do you drink alcohol?	☐	☐
If so, how much? _____		
Do you smoke?	☐	☐
If so, how much? _____		
History of alcohol or drug abuse?	☐	☐

Do you have any disease, condition, or problem not listed previously that you feel we should know about?

If so, please describe: _____

_____

During the past 12 months, have you taken any of the following?

	YES	NO
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Nonprescription drug/supplements	☐	☐
Bisphosphonates	☐	☐
Use of recreational drugs	☐	☐
Other _____		

Women	YES	NO
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date: _____		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐

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. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care and third party payors and/or health practitioners.

X _____ Date _____

Signature of patient (or parent/guardian if minor)

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Appointments, Financial Procedures, Insurance

Patient Name:_____Date:_____

On behalf of our staff, we appreciate the trust you have placed in us. We will make every attempt to honor that trust by providing the quality of dental care you require and deserve. One of our primary concerns will be for you to feel comfortable in our office.

APPOINTMENTS

We attempt to schedule appointments that are the most convenient for you. To help you more efficiently we reserve appointment times. Occasional emergencies or unforeseen occurrences may cause delays in our schedule. We will make every attempt to honor your appointment time. Please, in turn, remember that the time we appointed for you is exclusively for you. Any changes in your schedule will affect ours as well. **To avoid a broken appointment fee we require at least 48 hours notice If you are unable to keep your appointment. The broken appointment fee is based on the length of your appointment, with a minimum fee of $35.**

FINANCIAL PROCEDURES

In the interest of better understanding, we believe financial arrangements must be completely understood and agreed upon before treatment is begun. Your treatment will be explained to you and you will be given an estimate of the fees, upon request. We accept cash, check, MasterCard, Visa, Discover, and American Express. **Accounts 30 days past due will incur a 1.8% per month interest and/or a service fee.**

INSURANCE

McAlpin Dental Group P.A. is NOT an in-network dental provider with any insurance company. As a service for you, we will complete, mail and monitor your dental claims and/or pre-authorizations. Insurance deductibles and portions of fees not covered by dental insurance are due when services are rendered. In most instances, what we will need from you is an insurance card so that we may access your carrier and clarify benefits. We would appreciate any benefit information (booklet, etc.) you may have. **If you direct benefits payable directly to McAlpin Dental Group P.A., please sign here:**_____. Upon receipt of insurance payment we will reconcile the amount and send you a statement of your balance. Financial obligations for dental treatment are between you and this office. The insurance company is responsible to you and not to this office.

It is our privilege to be of service to you. Should you have any questions, please feel free to discuss them with our business staff. We thank you for the confidence you have placed in us. Our goal is for your visits to our office to be as pleasant as possible.

Patient Signature:_____Date:_____

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Consent for Use and Disclosure of Health Information

With my consent, McAlpin Dental Group and staff may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPHO). I have the right to review the Notice of Privacy Practices prior to signing this consent.

With my consent, McAlpin Dental Group and staff may email or call my home or other designated location to leave a message on voice mail or in person in reference to any matter that assists the practice in carrying out TPHO. These matters will include appointment reminders, insurance items, account statements, or any calls pertaining to my dental care. By signing this form I am consenting to McAlpin Dental Group and staff to use and disclose my protected health information only to carry out treatment, payment, and healthcare operations.

I consent to disclosing all of my protected health information, treatment, and payment and healthcare operations to (family member)?_____

_____ _____

Signature of **Patient** or Legal Guardian

Printed Name of **Patient** or Legal Guardian

_____ _____

Print **Patient** Name

Date

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Medications List

Patient Name: _____ **Date:** _____

	Name of Medication	Dosage	Reason Prescribed
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
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17.			
18.			
19.			
20.			

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Dental Comfort Evaluation

Patient Name:_____ **Date:** _____

On a scale of 0 to 5, where 0 is so relaxed you could fall asleep and 5 is the point when you are so fearful you want to faint, become sick, or run out of the treatment room, please rate the following situations.

1. _____ **Sitting in the reception room.**
2. _____ **Smelling the "smell" of a dental office.**
3. _____ **Sitting up in a dental chair.**
4. _____ **Reclining in a dental chair.**
5. _____ **Seeing the needle and syringe for anesthesia.**
6. _____ **Receiving the anesthesia injection.**
7. _____ **Hearing the noise of the dentist's drill.**
8. _____ **Having a tooth drilled.**
9. _____ **Seeing the dental instruments.**
10. _____ **Having the dental instrument manipulated in your mouth.**
11. _____ **The dentist walking into the treatment room.**
12. _____ **Having your teeth cleaned.**
13. _____ **Having dental X-rays taken.**
14. _____ **Other:**_____

Comments:_____

_____

_____

_____