McKenna Family Dentistry
1691 El Camino Real, Suite 300
Palo Alto, CA 94306-1009
(650)-321-4544

Patient_____M☐F☐Date_____
Last First Middle
Name you would like to be called:_____Mr.☐Mrs.☐Ms.☐Miss☐Dr.☐
Social Security#_____Birth date_____Kaiser#_____
Residence Address_____
City_____State_____Zip_____
Phone Home#_____Work#_____Cell#_____
Pager#_____E-Mail_____
Employer/School_____Phone #_____
Dental Insurance Carrier_____Group#_____

Is there Secondary Insurance? Yes No If so, then fill out below
Subscribers Name_____ Social Security #_____ Birth date_____
Employer/School_____Phone#_____
Dental Insurance Carrier_____Group#_____

Whom may we thank for referring you?_____

Dental History

Reason for today's visit:_____
When was you last dental visit?_____Date of last dental xrays:_____
What was done:_____
Name, address, and phone# of previous dentist:_____
Have you or are you currently undergoing:
If yes, please provide the doctor's name.
Periodontal treatment ☐Yes/No☐ Doctor's Name_____
Orthodontic treatment ☐Yes/No☐ Doctor's Name_____
Oral Surgery (extractions) ☐Yes/No☐ Doctor's Name_____
Are your teeth sensitive to: Heat☐Yes/No☐ Cold☐Yes/No☐ Sweets☐Yes/No☐
Biting/Pressure☐Yes/No☐ Does food collect between teeth?☐Yes/No☐
Do your gums bleed while brushing/flossing? ☐Yes/No☐
How often do you brush?_____x's per dayFloss?_____x's per week
Do you use: Electric toothbrush?☐Yes/No☐ Rubber tip?☐Yes/No☐ Toothpicks?☐Yes/No☐
Do you clench/grind your jaws?☐Yes/No☐ While sleeping?☐Yes/No☐ During the day?☐Yes/No☐
Are you happy with the appearance of your teeth?☐Yes/No☐
Is it important to you to keep your teeth?☐Yes/No☐
Have you ever had an upsetting experience in the dental office? If so, please explain:
_____

Please add anything you think is important or helpful:

_____

Medical History

General Health: Excellent☐ Good ☐ Fair☐ Poor☐
Name & address of physician: _____
Have you ever been instructed to take antibiotics prior to any dental appointments?☐Yes/No☐
Have you ever taken the following? Redux☐, Fosamax☐, Boniva☐, Actonel☐, Reclast☐ or any other medications containing bisphosphonates?☐Yes/No☐
Are you currently taking any medications?☐Yes/No☐(including birth control, aspirin, etc.)
If Yes, please list:_____
Are you currently under medical treatment?☐Yes/No☐For what condition?_____
Have you been hospitalized within the last 2 years?☐Yes/No☐For what?_____
Have you ever reacted adversely to any of the following?

_☐_ Local Anesthesia (i.e. novocaine) _☐_ Metal _☐_Sulfa drugs
_☐_ Narcotics (i.e. codeine, demeral) _☐_ Penicillin _☐_Ibuprofen
_☐_ Aspirin _☐_ Antibiotics, other
_☐_ Latex _☐_ Acrylic

If you have answered yes to any of the above, please explain: _____

_____

Do you smoke?☐Yes/No☐ If yes, how much?_____
For women only: **Are you pregnant?☐Yes/No☐ If yes, when are you due?_____**
Do you have, or have you had, any of the following?
Please place an X next to any conditions that apply to you.

☐AIDS/HIV Positive
☐Alzheimer's Disease
☐Anaphylaxis
☐Anemia
☐Angina
☐Arthritis/ Gout
☐Artificial Heart Valve
☐Artificial Joint
☐Asthma
☐Blood Disease
☐Blood Transfusion
☐Breathing Problem
☐Bruise Easily
☐Cancer
☐Chemotherapy
☐Chest Pains
☐Congenital Heart Disease
☐Convulsions
☐Cortisone Medicine
☐Diabetes
☐Drug Addiction
☐Emphysema
☐Epilepsy/Seizures
☐Excessive Bleeding
☐Excessive Thirst
☐Fainting/Dizziness
☐Frequent Cough
☐Frequent Diarrhea
☐Frequent Headaches
☐Genital Herpes
☐Glaucoma
☐Hay Fever
☐Heart Attack
☐Heart Murmur
☐Heart Pacemaker
☐Heart Disease
☐Hemophilia
☐Hepatitis A B or C
☐Herpes / Cold Sores
☐High Blood Press.
☐High Cholesterol
☐Hives or Rash
☐HPV
☐Hypoglycemia
☐Irregular Heartbeat
☐Kidney Disease
☐Leukemia
☐Liver Disease
☐Low Blood Press.
☐Lung Disease
☐MVP
☐Osteoporosis
☐Pain in Jaw Joints
☐Psychiatric Care
☐Radiation TX
☐Recent Weight Loss
☐Rheumatic Fever
☐Scarlet Fever
☐Shingles
☐Sickle Cell Disease
☐Sinus Trouble
☐Stomach Disease
☐Stroke
☐Swelling of Limbs
☐Thyroid Disease
☐Tonsillitis
☐Tuberculosis
☐Tumors or Growths
☐Ulcers

Have you ever had an serious illness not listed about?☐YES OR NO☐If Yes, explain_____

I,_____authorize McKenna Family Dentistry to examine and provide medical treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to McKenna Family Dentistry. I authorize McKenna Family Dentistry to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand it is my responsibility to know all rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, x-ray departments and specialists and specialist providers which are assigned to me according to my insurance policy rule. It is McKenna Family Dentistry's procedure to share Protected Health Information with labs, x-rays, consulting physicians and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

_____ _____

Patient or Responsible Party Signature **Date**

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.

I acknowledge that I have been provided with and understand this facility's Notice of Privacy Practices provides a complete description *of* the uses and disclosures of my health information.

I understand that:

- **I have the right to review this facility's Notice *of* Privacy Practices prior to signing this acknowledgement.**
- **This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.**

_____
Signature *of* Individual or Legal Representative Witness

_____
Printed Name of Individual or Legal Representative

Witness…….…… …… Date:……..

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because: (circle one)

- **❑Individual refused to sign**
- **❑Communication barrier prohibited obtaining the acknowledgement**
- **❒ An emergency situation prevented us from obtaining acknowledgement**
- **❒ Other: (please specify)**

_____
_____

_____ _____
HIPAA Officer Date

Consent and Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

(Revised March 2013)

I, _____ (Patient's Name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

• a basis for planning my care and treatment;
• a means of communication among the health professionals who may contribute to my healthcare;
• a source of information for applying my diagnosis and surgical information to my bill;
• a means by which a third-party payer can verify that services billed were actually provided;
• a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

I understand that:

• I have the right to review this facility's Notice of Information practices prior to signing this consent;
• This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
• I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
• I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
• It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.
• I have the right to restrict disclosure of PHI to a health plan with respect to treatment for which the individual has paid fully out-of-pocket.

_____
Signature of Patient or Legal Representative Witness

_____ _____
Printed Name of Patient or Legal Representative Witness **Date**

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

I, _____ acknowledge I have received from McKenna Family Dentistry a copy of the Dental Materials Facts Sheet dated October 2001.

_____ _____

Patient Signature **Date**

Patient Acknowledgement of McKenna Family Dentistry's Cancellation Policy

I, _____ acknowledge I have read the following statement.

"If you are unable to keep your dental appointment we require 24 business hours notification in order to avoid the failed appointment fee of $50."

_____ _____

Patient Signature **Date**

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CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon direct reimbursement from patients for the cost incurred in their care. The financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time of services.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient, and that he or she is personally responsible for payment of the services. This office will prepare your insurance forms, assist you in making collections from your insurance company, and will credit any such collections to your account. However, this dental office does not render services on the assumption that our charges will be paid partially, or in their entirety, by an insurance company.

I, give McKenna Family Dentistry permission to charge my credit card if there is any remaining balance on my (family) account. My credit card number will not be kept on file in MFD's computer system. It is processed by our merchant services company and protected. I will receive an email as my receipt after a transaction has been processed. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 990 days, unless previously written financial arrangements are satisfied.

I understand that fee estimates for dental care are only and estimate of the costs for services. Costs for dental services may vary from those quoted, as may the estimated insurance. We make every effort to provide you with an estimate of your portion and your insurance's portion based on the current insurance information you have provided. But we make no guarantee or warrantee that this estimate of coverage for your dental services is correct. Fee estimates are valid for a period of six month from the date the estimate was given.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me , in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I further grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment, financial responsibility and agree to their content.

_____

Print Name

_____ _____

Signature **Date**