



**Assignment of Benefits (if covered by insurance):** I direct that my insurance company pay the benefits for treatment directly to McCalla Orthodontics & Pediatric Dentistry. I assign to the dental office for the purpose of security, any right I may have to receive such payment directly from the insurance company, and hereby revoke any prior authorizations which I may have given to the contrary. I agree to cooperate fully with the office efforts to obtain payment under such policy and will execute any additional documents my insurance company may require in order to process the office claim. In the event of any overpayment of insurance benefits, (as where two policies are subject to a coordination of benefits) I authorize McCalla Orthodontics & Pediatric Dentistry to refund to the company making such overpayment.

**Payment Policy:** I understand that by signing below I agree to pay for services rendered, whether or not I am the patient. I agree that I will pay this bill in full whether or not charges are or should have been covered by insurance. I have been advised that the office does not extend credit and that payment is due in full at time of service. I agree that if this account is not paid when due, and if the office should refer it to an attorney for collection, I will pay all costs of the collection including interest, and a reasonable attorney's fee (even if suit is not filed). I hereby waive all rights of exemption which are available to me under the law of Alabama or the United States.

Any Returned checks will be assessed a \$30.00 Charge. By law, your bank informs you of a dishonored check. We expect you to contact us to make arrangements for settling the full amount of the check plus \$30.00 within ten (10) days. Late payment charges will be assessed if the matter is not settled by that time. All other policy provisions as noted above apply, including collection.

We thank you for your cooperation and look forward to providing the highest quality dental care for your children with a clear understanding of each party's responsibilities.

**Appointment Cancellation Policy:** We require a 24 hour notice of change in appointments. We reserve the right to charge a \$30.00 fee for missed appointments and appointments changed with less than a 24 hour notice.

I have read and fully understand the above financial policy and accept all provisions.

Name \_\_\_\_\_

Date \_\_\_\_\_

Relationship to patient \_\_\_\_\_

**MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area 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 If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No \_\_\_\_\_
- Do you use tobacco?  Yes  No \_\_\_\_\_
- Do you use controlled substances?  Yes  No \_\_\_\_\_

Women: Are you \_\_\_\_\_

Pregnant/Trying to get pregnant?  Nursing?

Taking oral contraceptives?

- Are you allergic to any of the following? \_\_\_\_\_
- Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics
- Other If yes, please explain: \_\_\_\_\_

- Do you have, or have you had, any of the following? \_\_\_\_\_
- |   |  |  |  |   |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive      | <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Alzheimer's Disease    | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes        | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Anaphylaxis            | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Angina                 | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Arthritis/Gout         | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Heart Pace Maker      | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Artificial Joint       | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints    | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Parathyroid Disease   | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Radiation Treatments  | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Breathing Problem      | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Recent Weight Loss    | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Renal Dialysis        | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatism            | <input type="checkbox"/> Yellow Jaundice            |

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

Dental History Pediatric Dentistry

Is today your child's first visit to the dentist? \_\_\_ Yes \_\_\_ No Explain \_\_\_\_\_

Purpose of this visit \_\_\_\_\_

Do we see other children in your family? \_\_\_ Yes \_\_\_ No

Names \_\_\_\_\_

Name of previous dentist: \_\_\_\_\_

Has child had any unfavorable dental experience? Explain: \_\_\_\_\_

How often does child brush teeth? \_\_\_\_\_ Floss? \_\_\_\_\_ Does someone assist child? \_\_\_\_\_

Has child ever had injury to face/teeth? \_\_\_ Yes \_\_\_ No Date: \_\_\_\_\_ Describe: \_\_\_\_\_

Are there any mouth habits? (please circle): finger, thumb, pacifier, tongue thrust, bruxism, mouth breather, other? \_\_\_ currently \_\_\_ previously \_\_\_ never

At what age was bottle/breast feeding discontinued? \_\_\_\_\_

Does your child eat frequent between meals, snacks? \_\_\_ Yes \_\_\_ No

How many children in child's family? \_\_\_\_\_ What ages? \_\_\_\_\_

Do you expect your child to cooperate for the exam? \_\_\_ Yes \_\_\_ No

Child's attitude about dentistry \_\_\_\_\_

Thank you for your help. If there is any information that you feel might be important to us in treating your child please comment: \_\_\_\_\_

# **AUTHORIZATION TO BE SEEN WITH OUT PARENT OR LEGAL GUARDIAN**

I, \_\_\_\_\_ the person legally  
responsible for \_\_\_\_\_

(patient name), allow Dr. Sanchez to provide any necessary treatment to \_\_\_\_\_

\_\_\_\_\_

(patient name) should he/she attend their dental appointment with anyone other than the  
parent/legal guardian. Below is a list of those who can come with patient:

1) Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

2) Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

3) Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Responsible Party Name (Print) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_