OUACHITA
DENTAL + IMPLANT CENTER

Patrick L. McGee, DDS
FELLOW, ACADEMY OF GENERAL DENTISTRY

ALL PAPERWORK MUST BE COMPLETED EVERY YEAR

Patient's Legal Name:_____ **Preferred Name:**_____

Birth Date____/_____/_____ ***SS#***_____-_____-_____**EMAIL:**_____

Address:_____**City**_____**State**_____**Zip Code**_____

Home Phone(_____)_____-_____**Cell Phone**(____)_____-_____**Male**_____**Female**____

Employer:_____**Work Phone**(____)_____-_____**Married**____**Single**____

Spouse Legal Name:_____Birth Date_____/_____/_____

SS# (If Ins. is in their name)_____/_____/____Cell Phone(____)_____-_____Employer_____

Primary Dental Ins. Company Name:_____Employer_____

Insured's Full Name:_____Relation_____Insured's DOB____/____/____

SS#_____-_____-_____Subscriber or Member ID_____

Emergency Contact:

Name_____ **Relation**_____ **Phone**_____

The following persons are authorized to have access to billing, appointment, and treatment information (person responsible for account must be listed)

Name:_____**Relation:**_____**Name:**_____ **Relation:**_____

I understand that the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I (or the minor patient) may need during diagnosis and treatment with my informed consent.

I understand I am responsible for payment of services at the time they are rendered. If this office participates with my insurance, I understand I am also responsible to pay any copayment and deductible at the time service is rendered.

Patient Signature:_____ **Date:**_____

COMPLETE ALL PAGES

MEDICAL HISTORY

(please complete all fields below or mark "None" for those that do not apply)

Cardiovascular Disease

- ☐ Angina / Chest Pain
- ☐ Arrhythmias
- ☐ Artificial Heart Vales
- ☐ Coronary Artery Disease
- ☐ History of Heart Attack
  Date(s):_____
- ☐ Hypertension
- ☐ Stents or Bypass Grafts
  Date(s):_____
- ☐ TIA or Stroke
- ☐ Other Heart Surgery
  _____
  Date(s):_____
- ☐ None

Endocrine and Metabolic Disorders

- ☐ Diabetes
  -Type I,Type II
- ☐ Osteopenia or Osteoporosis
- ☐ Thyroid Disease
- ☐ Vitamin D Deficiencies
- ☐ Other(s):
  _____
- ☐ None

Gastrointestinal and Liver Disease

- ☐ Cirrhosis
- ☐ Fatty Liver
- ☐ Gatroesophageal Reflux (GERD)
- ☐ History of Hepatitis
  -Type: A, B, C, D, E
- ☐ Peptic Ulcers
- ☐ Other(s):
  _____
- ☐ None

Hematologic Disorders/Cancer

- ☐ Bone Marrow Disease
- ☐ Cancer
  -Type:_____
  -Treatment:_____
  -Date(s):_____
- ☐ Hemophilia
- ☐ Spontaneous Bleeding
- ☐ Thrombocytopenia
- ☐ von Willebrand's Disease
- ☐ Other(s):
  _____
- ☐ None

Kidney Disease

- ☐ Chronic Kidney Disease
  -Stage:_____
- ☐ Dialysis
- ☐ Uremia
- ☐ Other(s):
  _____
- ☐ None

Pulmonary Disease or Breathing Disorder

- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Obstructive Sleep Apnea
- ☐ Shortness of Breath
- ☐ Other(s):
  _____
- ☐ None

Other Conditions

- ☐ Alcohol and/or Tobacco Use
- ☐ HIV/AIDS
- ☐ Joint Replacements
  -Joint: _____
  -Date(s):_____
- ☐ Seizures
- ☐ Any Condition(s) not listed:
  _____
- ☐ None

Any known Allergies:

_____

Past Surgeries and/or Hospitalizations:

_____

Current Medications:

_____

_____

_____

Preferred Pharmacy, Address, and Phone: _____

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NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and healthcare operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that is maintained. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature:_____ Date_____