Kiamesha McClellan, D.D.S.

2200 Morriss Rd., Suite 150
Flower Mound, TX 75028
Phone: 972-539-4290
Fax: 972-355-1736

ADULT PATIENT REGISTRATION

PATIENT INFORMATION:

Last Name _____ First Name _____ M.I. _____

Address _____

City _____ State _____ Zip _____

Home #_____ Cell#_____ Work# _____

Employer_____ Social Security #_____

Birthdate _____ Age _____ Sex (Please Circle) Male Female

E-MAIL _____

Emergency Contact _____ Phone #_____

RESONSIBLE PARTY – HOLDER OF INSURANCE POLICY:

Last Name _____ First Name _____ M.I. _____

Address _____

City _____ State _____ Zip _____

Home #_____ Cell#_____ Work# _____

Employer_____ Social Security #_____

Birthdate _____ Age _____ Sex (Please Circle) Male Female

Primary Insurance Company _____ Phone# _____

Group # _____ ID#_____

AS A COURTESY TO YOU, WE WILL FILE YOUR CLAIMS WITH YOUR INSURANCE COMPANY. HOWEVER, IT IS YOUR RESPONSIBILITY TO MAKE SURE THEY PAY YOUR BILL. IF THEY DO NOT PAY WITHIN 90 DAYS OF SERVICES RENDERED, IT THEN BECOMES YOUR RESPONSIBILITY TO PAY YOUR BILL AND HAVE THE INSURANCE COMPANY REIMBURSE YOU DIRECTLY.

ALL PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, AND CARE CREDIT

PATIENTS SIGNITURE:_____ DATE: _____

Flower Mound Dentistry DiVine

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	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 ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you use controlled substances? Yes No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
						Yellow Jaundice	Yes No

Have you ever had any serious illness not listed Yes No If yes

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:

X _____ Date:_____

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ADULT MEDICAL AND DENTAL HEALTH HISTORY

Date:_____

Last Name _____ First Name _____M.I. _____

Date of Birth: _____Physician's Name: _____

Reason for dental visit:_____

How did you hear about our office? _____

	Dental History	Yes	No
1.	Have you had trouble from previous dental care?		
2.	Do you have pain in your jaw or near your ears?		
3.	Do you have any unhealed injuries or inflamed areas in or around you mouth?		
4.	Have you experienced any growths or sore spots in your mouth?		
5.	Does any part of your mouth hurt when clenched?		
6.	Have you ever had Novocaine or other local anesthetic?		
7.	Have you ever had Nitrous Oxide (laughing gas)?		
8.	Have you ever had general anesthesia?		
9.	Have you ever had any reaction or allergic symptoms to Novocaine, local or general anesthetics?		
10.	Have you ever had any difficult extractions in the past?		
11.	Have you ever had prolonged bleeding following extractions in the past?		
12.	Do your gums bleed?		
13.	Do you have a bad taste in your mouth or mouth odor?		
14.	Have you ever had instructions on the care of your gums?		
15.	Do you chew on only one side of your mouth? If so, why?		
16.	Do you habitually clench or grind your teeth during the day or night?		
17.	Is any part of your mouth sensitive to pressure irritants (hot, cold, or sweet)?		

_____ _____ _____ _____

Patient's Signature Date Dentist's Signature Date

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FINANCIAL POLICY

We would like to take this time to say thank you for allowing us the opportunity to provide for all of your dental needs. We are committed to your treatment being the best possible. We hope that you will find our office staff to be caring, considerate, and professional. If any problems should arise, please feel free to bring it to our attention. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

- Patient's balance is due at the time of service unless prior financial arrangements have been made.
- Full payment is due if insurance cannot be verified.
- We accept cash, checks, Visa, MasterCard, Amex, and Discover.
- We offer an extended payment plan with prior credit approval through Care Credit.
- There is a cancellation fee of $50.00 for any broken appointment without a 24hr notice.

INSURANCE

We will gladly process your insurance claims on your behalf. This is a courtesy we extend to you to help keep the cost of quality dental care affordable. Payment of your estimated cost of treatment is due at the time of service. The estimates obtained in this office are subject to final approval by your insurance company, therefore the amount due is subject to change. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We fully expect the patient to be knowledgeable of the benefits covered by their policy. If your insurance company has not paid your account in full within 90 days, you will be responsible for paying the balance and then getting reimbursed from your insurance company.

Usual and Customary Rates.

Our practice is committed to providing the best treatment for our patients and we charge what are usual and customary fees for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

_____ _____

Signature of Patient or Responsible Party Date

_____

I.D./Driver's License State and Number