McMillen Dental

106 McMillen Drive
Newark, Ohio 43055
740-344-1171

New Patient Information, please fill out below:

Date:_____ Name: _____ Spouse:_____

Address:_____

City:_____ State:_____ Zip:_____ DOB:_____

SSN:_____ Driver's License #:_____ Email:_____

Home Phone #:_____ Cell Phone #:_____

Married:_____ Single:_____ Divorced:_____ Widowed:_____

Female:_____ Male:_____

Person Responsible for Account, unless same information as above:

Date:_____ Name:_____ Spouse:_____

Address:_____

City:_____ State:_____ Zip:_____ DOB:_____

SSN:_____ Driver's License #:_____ Email:_____

Home Phone #:_____ Cell Phone #:_____

Getting to know you:

Referred to us by:_____ Occupation:_____

Employer:_____ Business phone #:_____

Is another member of your family or relative a patient at our office? Name_____

Person to contact for an emergency: Name:_____ Phone #:_____

Address:_____ City:_____ State:_____

Closest Relative NOT living with you: Name:_____ Phone #:_____

Address:_____ City:_____ State:_____

Dental Insurance Information: *if you have your insurance card with you please give to Receptionist to make a copy. If you were NOT provided with a dental insurance card and still carry dental insurance, please fill out the information below:

Primary Insurance:

Insurance Company:_____ Phone #:_____

Employer:_____ Employee DOB:_____ SSN:_____

Secondary Insurance:

Insurance Company:_____ Phone #:_____

Employer:_____ Employee DOB:_____ SSN:_____

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Medical History **Patient Name:**_____

1. Are you having pain or discomfort at this time? **YES** **NO**
2. Have you been a patient in the hospital during the last two years? **YES** **NO**
3. Have you been under the care of a medical doctor during the past two years? **YES** **NO**
   Physician's Name_____
   Address_____ **Phone Number:** _____
4. Have you taken any medicine or drugs during the past two years? **YES** **NO**
   If yes please list_____
5. **Are you allergic or have you reacted adversely to any of the following medications?**

• Aspirin	Percodan	Amoxicillin
• Codeine	Tylenol	Vicodin
• Demerol	Valium	Ibuprofen
• Nitrous Oxide	Keflex	Sulfa
• Erythromycin	Penicillin	
• Tetracycline	Local Anesthetic	

6. Are you aware of being allergic/sensitive to any other medications or substances?
   _____
   If yes please list:_____

7. **Circle which of the following you have had OR currently have:**

• Angina Pectoris	Allergies or Hives	Bruise Easily
• High Blood Pressure	Diabetes	Sickle Cell Disease
• Heart Murmur	Thyroid Disease	Ulcers
• Congenital Heart Lesions	Radiation Treatment	Chemotherapy
• Scarlet Fever	Arthritis	Cancer
• Heart Pacemaker	Rheumatism	Sleep Apnea
• Heart Surgery	HIV	MVP
• Heart Disease	Hepatitis	Stroke
• Heart Attack	Liver Disease	Downs Syndrome
• Artificial Joints	Yellow Jaundice	Are you Pregnant?
• Anemia	Blood Transfusion	**yes** **no**
• Emphysema	Drug Addiction	If yes due date_____
• Cough	Hemophilia	Sinus Trouble
• Tuberculosis	Mouth Sores	Fainting or Dizzy Spells
• Asthma	Epilepsy or Seizures	Parkinson's Disease
• Autism and/or ADHD	Acid Reflux	

8. Do you have a Latex Allergy? **YES** **NO**
9. Have you been told by your doctor you need Premedication before dental treatment? **YES** **NO**

10. Have you had any surgeries that have required you to have rods, pins or plates placed? **YES** **NO**
11. List any major surgeries:_____
12. Do you have any disease, condition, or problem not listed? **YES** **NO**
13. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired? **YES** **NO**
14. Do you smoke or use smokeless tobacco and if so how much? **YES** _____ **NO**

14: Would you like to share with us your previous dentist in case we may need to obtain previous dental records (i.e. dental x-rays) _____.

15: Consent: The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms treatment, medication, and therapy that may be indicated in connection with (name of patient)_____ _____and further authorize and consent that the doctor choose and employ such assistance as he/she deems fit. I also understand the use of anesthetic agents embodies a certain risk. **I understand that it is my responsibility to notify the doctor of any changes in my health or address history.**

Parent or Guardian of minor: _____ **Date:** _____

Patient Signature:_____ **Date:**_____

McMillen Dental Financial Agreement

I authorize the Insurance Manager of McMillen Dental to collect and apply for the account within McMillen Dental. I also authorize the Insurance Manager of McMillen Dental to collect any of the insurance amounts for the family under any contract of insurance for services performed at the office. I understand that my dental insurance is a contract between myself and the insurance carrier and not between the insurance carrier and the dentist and I am responsible for all dental fees. This authorization will remain in force and effect until the office of McMillen Dental receives written notice. I also understand that it is my responsibility to notify McMillen Dental of any changes in my dental insurance carrier.

All financial arrangements are made before scheduling any treatment. I understand that the portion of treatment for myself or dependents that is not covered by my insurance is due and payable at each visit unless other financial arrangements have been made. **I also assign all insurance benefits to the Doctors of McMillen Dental.** I understand the person who brings the minor child is financially responsible. I further understand that if the account is not paid within sixty (60) days of the billing date, a charge of $2.00 per month will be accessed on the unpaid balance. There will be a thirty dollar ($30.00) additional charge for any returned checks that are written to the Owner or the office of McMillen Dental. A missed appointment is a loss to everyone, IF you are unable to keep an appointment; we ask that you kindly provide a minimum of two business day notice and that you contact the office during our normal business hours to change an appointment. This courtesy on your part will allow us to give your appointment to another patient who needs to see the Doctor.

In the event of default I (we) promise to pay all legal cost on the indebtedness, together with such collection costs and reasonable fees accrued as may be required in effect collection of your account.

(Acknowledges and Accepted)

_____

(Sign) (Date)