Scottsdale DENTAL ARTS

Jason D McCargar DMD, LTD

Getting to know you…

Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐

First Name: _____ Last Name: _____

Social Security Number: _____

Your Date of Birth: _____

Your Address: _____

City: _____ State: _____ Zip: _____

Marital Status: _____

Home Phone #: _____ Work #: _____

Cell Phone #: _____

Preferred e-mail address: _____

May we add you to our e-mail contact list? Yes ☐ No ☐

Where do you work? _____

What is your occupation? _____

Who do we have the pleasure of thanking for referring you? _____

_____

Your family and interests….

Your Spouse/Partner: _____

Do you have any children or other dependents?: Yes ☐ No ☐

What are their names and ages? _____

_____

What are your hobbies? _____

What is your favorite sports team? _____

What kind of music do you listen to? _____

Name the best restaurant in Scottsdale?_____

What do you do to relax? _____

Please tell us about your Dental Insurance…

Your Primary Dental Insurance: _____

Group Number: _____

Plan or Policy Number: _____

Insurance Address: _____

City: _____State: _____Zip: _____

Number of Insurance Carrier: _____

Name of Insured: _____

Your relationship to the above Insured: _____

Date of Birth of Insured: _____
Social Security of Insured: _____
Insured's employer: _____

Your Secondary Dental Insurance…

Name of Insurance Carrier: _____
Group Number: _____
Plan or Policy Number: _____
Insurance Address:_____
City:_____ State:_____ Zip: _____
Phone Number of Insurance Carrier: _____
Name of Insured:_____
Your relationship to the above Insured: _____
Date of Birth of Insured: _____
Social Security of Insured: _____
Insured's employer: _____

Please tell us about today's visit to Scottsdale Dental Arts….

How can we serve you today? _____
_____
When was the last time you went to the dentist?_____
Do you have any teeth that cause you pain?_____
What do you like most about your smile?_____
What would you like to improve about your smile?_____
_____

Your Overall Health…

Are you under the care of a Physician? Yes ☐ No ☐
If so, what is your Physician's Name: _____
Practice address: _____
Practice phone number: _____
When was the last time you were seen by your Physician? _____
And for what purpose? _____
_____
How would you describe your overall health?
☐ Excellent ☐ Fair
☐ Good ☐ Poor
Are you currently under care for a chronic condition? Yes ☐ No ☐
If so, please describe: _____
_____

For Women:

Are you pregnant? Yes ☐ No ☐
Are you taking birth control? Yes ☐ No ☐
Are you nursing? Yes ☐ No ☐

Your medical history…

	Yes	No		Yes	No		Yes	No
Abnormal Bleeding	☐	☐	Fainting Spells	☐	☐	Nervous Problems	☐	☐
Alcohol/Drug Abuse	☐	☐	Frequent Headaches	☐	☐	Pacemaker	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Psychiatric Disorders	☐	☐
Arthritis	☐	☐	Hay Fever	☐	☐	Radiation Therapy	☐	☐
Artificial Joints/Valves	☐	☐	Heart Attack	☐	☐	Respiratory Disease	☐	☐
Asthma	☐	☐	Heart Murmur	☐	☐	Rheumatic Fever	☐	☐
Blood Disease	☐	☐	Heart Surgery	☐	☐	Seizures	☐	☐
Blood Transfusion	☐	☐	Hemophilia	☐	☐	Shingles	☐	☐
Cancer	☐	☐	Hepatitis	☐	☐	Sickle Cell Disease	☐	☐
Chemotherapy	☐	☐	Herpes/Fever Blisters	☐	☐	Sinus Problems	☐	☐
Circulatory Problems	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
Colitis	☐	☐	HIV/AIDS	☐	☐	Swollen Feet/Ankles	☐	☐
Congenital Heart Disease	☐	☐	Hospitalized before?	☐	☐	Swollen Neck Glands	☐	☐
Cortisone Treatments	☐	☐	Jaundice	☐	☐	Thyroid Problems	☐	☐
Cough, persistent/bloody	☐	☐	Jaw Pain	☐	☐	Tonsillitis	☐	☐
Diabetes	☐	☐	Kidney Problems	☐	☐	Tuberculosis	☐	☐
Difficulty Breathing	☐	☐	Liver Disease	☐	☐	Tumor/Growth	☐	☐
Emphysema	☐	☐	Low Blood Pressure	☐	☐	Ulcers	☐	☐
Epilepsy	☐	☐	Mitral Valve Prolapse	☐	☐	Venereal Disease	☐	☐

Previous or current tobacco use? Yes ☐ No ☐

If yes, type and years of usage: _____

Are you aware of any serious medical conditions? Yes ☐ No ☐

Explain: _____

What medications are you currently taking? _____

_____

Are you taking any over-the-counter or herbal remedies? _____

_____

Do you have any drug allergies? _____

_____

Do you have other allergies? _____

_____

Have you ever had an adverse reaction to any of the following?

- ☐ Antibiotics
- ☐ Aspirin
- ☐ Codeine
- ☐ Dental anesthetics (Lidocaine/Novocain)
- ☐ Latex
- ☐ Penicillin
- ☐ Pain Medications
- ☐ Other _____

Are there any other conditions about your overall health that we should be informed about?

_____

_____

Jason D. McCargar D.M.D., Ltd.

9751 North 90th Place Scottsdale, Arizona 85258
480-860-8282

For patients with Insurance:

Benefits for dental treatment vary from plan to plan. Additionally, "Out of Network" benefits are subject to deductibles that vary with each plan. In an effort to provide clear communication with our patients, please be advised as follows:

- We are a contracted provider of Delta Dental "Premier". Any other PPO or Indemnity insurance will be considered "out of network".
- The contractual agreement for your dental benefits is between you and the insurance company. **We provide billing as a courtesy.**
- For all insurance carriers that we have a contractual agreement with, we will accept the "In Network" benefits outlined on your individual Explanation of Benefits. You will still be responsible for any and all co-pays, deductibles or co-insurance amounts due in accordance with explanation of benefits.
- For all patients with a non-contracted insurance company, you will be responsible for all charges not covered by your plan.
- When insurance benefits have been exhausted and/or terminated, you will be responsible for the charges incurred.
- Our staff will call to verify dental coverage and according to your insurance this is **NOT** a guarantee of payment, just verification of benefits. We cannot be held responsible for percentages or benefits estimated with this information.
- In all cases, you will be responsible for any non-covered service, deductible, co-pays and co-insurance amounts deemed as patient responsibility by your insurance company.
- **However, it is your responsibility to know your dental plan coverage.**

For patients with and without insurance:

- Payment is due when services are rendered. Accounts may be assessed a late charge of 1 ½ % per month, not to exceed 18% interest. If an account is sent to collections a collections fee will be added to your account.
- Should your account be placed in collection, you will be responsible for any and all fees and court costs incurred.

I have read and agree to be financially responsible for all services performed by Dr. Jason McCargar and staff.

_____

Patient

_____

Date

_____

Parent or Guardian for children under 18

Jason D. McCargar D.M.D., Ltd.

9751 North 90th Place Scottsdale, Arizona 85258
480-860-8282

-.-

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient giving Consent

Name____

Address____

Telephone______________________________ **E-mail**____________________________
Social Security__________________________ **Patient #**__________________________

Section B: The Patient-Please read the following statements carefully.

PURPOSE OF CONSENT: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice Of Privacy Practices before you decide to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice is available at the front desk, we encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised copy which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any versions of our Notice by contacting:

Contact Person: Any office administrator Telephone: 480-860-8282
Office: 9751 North 90th place, Scottsdale, Arizona 85258

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that the revocation of this consent will not affect any action we took in reliance of your Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

Name: I,__________________________________, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices, I am giving my consent to your use and disclosure of my protected health information to carry out our treatment payment activities and health care operations.

Signature 2.__________________________Date_____________________
If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal representatives name: _____________________________Relationship _______________