Welcome to McCall Dentures and Family Dentistry

Thank you for selecting our dedicated team to partner with you in your denture and/or dental care needs. We will strive to provide you with the best possible experience. To help us meet your needs, please take the time complete these forms to the best of your knowledge. If you have any questions or need help completing the forms, please ask for assistance. We are happy to help!

Patient Information

Date _____

Name _____ Preferred Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Driver's License #/State _____

Date of Birth _____ SS # _____ Circle One: Minor Single Married

Patient Employer _____ Work Phone _____

How did you hear about McCall Dentures? _____

Spouse or Legal Guardian

Relationship to patient (circle one) Spouse Parent Other

Name _____ Date of Birth _____

SS # _____ Cell Phone _____ Driver's License #/State _____

Employer _____ Work Phone _____

Insurance Information

If you have insurance **please present your card to the receptionist** and we will scan the card for reference. Insurance is filed by this office as a courtesy to the patient. The patient needs to be aware of the benefits their insurance provides and all fees of service will be the responsibility of the patient (or responsible party) regardless of insurance coverage.

I understand and agree to the insurance acceptance guidelines above. I authorize McCall Dentures to provide my insurance company with the information necessary to submit a claim.

Signature _____

Date _____

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

I, (please print) _____ have had the opportunity to review this office's Notice of Privacy Practices.

Signature _____ Date _____

McCall Dentures and Family Dentistry

Patient Name _____ Date _____

Reason for today's visit _____

Patient Dental History

Name of Previous Dentist _____ Office Phone _____ Date of Last X-Rays_____

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing?	___	___	Do you have frequent headaches?	___	___
Are your teeth sensitive to hot or cold?	___	___	Do you clench or grind your teeth?	___	___
Are your teeth sensitive to sweet liquids/foods?	___	___	Do you bite your lips or teeth frequently?	___	___
Do you feel pain in any of your teeth?	___	___	Have you had difficult extractions?	___	___
Do you have any sores or lumps in or near your mouth?	___	___	Do you like your smile?	___	___
Are you having pain in your jaw joints?	___	___	Do you have dentures or partials?	___	___
Have you received instructions on tooth/gum care?	___	___	Are they comfortable?	___	___

Medical History

Do you or have you had any of the following:

	Yes	No		Yes	No
High Blood Pressure	___	___	Cancer	___	___
Heart Disease	___	___	Radiation Therapy	___	___
Chest Pains	___	___	Stroke	___	___
Heart Attack	___	___	Diabetes	___	___
Cardiac Pacemaker	___	___	Kidney Disease	___	___
Heart Murmur	___	___	Liver Disease	___	___
Easily Winded	___	___	Tuberculosis	___	___
Unexplained Weight Loss	___	___	Ulcers	___	___
Low Blood Pressure	___	___	Anemia	___	___
Fainting/Seizures	___	___	Sinus Problems	___	___
Epilepsy/Convulsions	___	___	HIV/AIDS/Hepatitis/Other STD's	___	___
Respiratory Problems/Asthma	___	___	Joint Replacement	___	___
Are you under medical treatment now?	___	___	If yes, explain _____		
Have you had any surgery or major illness in the last five years?	___	___	If yes, explain_____		
Do you use tobacco? If yes, how often? _____	___	___	Do you use controlled substances?	___	___

Are you allergic to or have sensitivities to any medications? _____ Explain _____

Please provide a comprehensive list of all medications you are currently taking: _____

_____

_____

I certify that I have read and understand the above information to the best of my knowledge and the answers have been accurately answered. I understand that providing incorrect information can be dangerous to my (or my child's) health. I understand that it is my responsibility to inform the dental office of any changes in medical status or medications.

_____

Signature of patient, parent, or guardian Date Doctor Signature