McLemore Dentistry, LLC

Restorative, Cosmetic, & Implant Dentistry

5740 Carmichael Road, Montgomery, AL 36117

Phone (334) 277-9570 Fax (334) 277-0152

Email: **scheduling@mclemoredmd.com** **Website**: **drmclemoredentistry.com**

Please return this completed form along with a copy of both sides of your dental insurance cards and driver's license (at least 5 days before your appointment) so that we may be prepared for your visit. You may **fax** (**334-277-0152)** during normal business hours of 7:00am-3:00pm M-Th, **email (scheduling@mclemoredmd.com),** or return by **mail**.

Patient Information

Date: ______/_____ /_______

Patient Name: ____ (__________________)
Last Name , First Middle Preferred Name

☐Male ☐ female Family Status: ☐single ☐married ☐widowed ☐divorced ☐separated ☐child

Social Security # _______-________-________ Birth Date ____/____/____ Age ____ Driver License # ________________

Phone (Home): (___)-____-________ (Work): (____)_____- _____Ext: ______Best Time to Call: _______☐am ☐pm

Cell Phone: (____)-_____-_________Fax: (___)-____-_________Email: __________________@________________

Are you using Social Media? [ ] Facebook [ ] Twitter [ ] Instagram [ ] Other __________________

Home Street Address: ______________________________________ Apartment #: _________

City: ___________________________________ State: _______________ Zip Code: __________

Person to contact in case of an emergency: Name: _____________________________________

Phone: ( )_________________ Relationship to you: __________________________________

Name of the Person you give us permission to discuss your dental treatment:

____
First. Last. Relationship to you

Whom may we thank for referring you to our practice? Name: ____

☐Another Patient ☐Friend ☐Relative ☐Dental Office ☐TV ☐Yellow Pages ☐Internet ☐Other

Please explain: ____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ parent or legal guardian ☐ the person responsible for payment

Last Name: ___________________________________ First Name: _________________ Middle: _________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐Widowed

Social Security # _____-______-_____ Birth Date: _____/_____/_______

Phone Home: (____)-_____-________ Work: (____)-______-__________ Ext.: _____Best Time to Call: _________

Employment Information

Employer Name: ______________________________________Occupation: ___________________________

How long employed: ________ [__] Months/ [___] Years   Work hours: ____________Phone __________________

Street Address: ___________________________________City: ___________State: ________ Zip Code: ______

Dental Insurance Information

Primary Dental Insurance

Dental Insurance Company / Plan : ____

Effective Date: _____/_____/_____Name of Insured: (as on your insurance card): __________________________________

Is the Insured a patient in our office? ☐ Yes ☐ No Insured's Birth Date: ___/___/___ ID #: ______________
Group #: ________________________ SS#: ____-____-_______

Insured's Employer: ____ City _____________State: _______

Patient's relationship to insured: ☐Self ☐ Spouse ☐ Child ☐ Other: _________________

Secondary Dental Insurance (Note; Many Secondary Dental Plans do not pay the same as if they are Primary)

Secondary Dental Insurance Company/ Plan ____

Effective Date: _____/_____/_____Name of Insured: (as on your insurance card): __________________________________

Is the Insured a patient in our office? ☐ Yes ☐ No Insured's Birth Date: ___/___/___ ID #: ______________
Group #: ________________________ SS#: ____-____-_______

Insured's Employer: ____ City _____________State: _______

Patient's relationship to insured: ☐Self ☐ Spouse ☐ Child ☐ Other: _________________

Please remember to attach a copy of the front and back of your dental insurance cards and your Driver's License so that we may verify your coverage and benefits 5 days before your first appointment with our office.

Health Information

List Daily Rx Medications / Prescriptions

Medication or Prescription	Reason for the Medication or Prescription
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10	10.
11.	11.
12.	12.

MEDICAL HISTORY

Have you ever had any of the following? Please check those that apply:

☐AIDS/HIV
☐Allergies
☐Alcoholism
☐Acid Reflux Disease
☐Anemia
☐Arthritis
☐Artificial Joints
☐Asthma
☐Blood Disease
☐Chemotherapy
☐Cancer
☐Diabetes
  ☐Diet controlled
  ☐Medication Rx
  ☐Take Insulin
☐Dizziness
☐Drug Addictions
☐Epilepsy

☐Excessive Bleeding
☐Fear of Dentists
☐Frequent Headaches
☐Fosamax, Boniva, Reclast, Aredia, Zometa,etc ___________
☐Glaucoma
☐Growths, Tumors,
☐Head/Face Injuries
☐Heart Disease/Attack
☐Heart Valve Problem
☐Hepatitis A, B, C
☐Hospitalizations
☐High Blood Pressure
☐Jaundice
☐Kidney Disease
☐Liver Disease
☐Major Surgery

☐Mental Disorders
☐Methyltrexate Rx
☐Mouth Injuries
☐Nervous Disorders
☐Osteoporosis
☐Pacemaker
☐Psychiatric Problems
☐Pregnant Now
  Due date:
☐Respiratory Problems
☐Rheumatic Fever
☐Sinus Problems
☐Smoker
☐Stomach Problems
☐Recent Steroid Rx's
☐Stroke
☐TMJ jaw problems

☐Tuberculosis
☐Thyroid Problems
☐Take Aspirin Daily
☐Take Blood Thinners
☐Venereal Disease
☐Codeine Allergy
☐Penicillin Allergy
☐Anesthetic Allergy
☐ Snoring/Sleep Apnea

Allergies Please List Below:

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:

Dental Health Information

Reason for today's visit: ☐Exam ☐Emergency ☐Consultation ____
Are you experiencing dental pain today? ☐No ☐Yes How long have you been in this pain?
____

Please check those that apply:

☐Discomfort, clicking, or popping in jaw ☐Red, swollen, bleeding gums ☐Sensitive tooth, teeth, gums ☐Blisters/Sores in or around the mouth ☐Lost/Broken Fillings ☐Teeth grinding	☐Ringing in Ears ☐Broken/Chipped Tooth ☐Stained Teeth ☐Locking Jaw ☐Bad Breath	☐Difficulty Chewing ☐Embarrassed to Smile ☐Would like Whiter teeth ☐Pain upon chewing ☐Use Smokeless tobacco ☐Smoke

My Concerns about Dental Treatment are : ☐ Fear ☐Finances ☐Time

Date of Last Dental Visit: _____/____/______ Reason for last dental visit: ____________________

Date of Last Complete Mouth or Panoramic Dental X-rays: ____/_____/_____

Date of Last Cleaning: _____/____/_____

Previous Dentist Name: __________________________________ City: _______________ State: ____________

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain:
____

How would you rate your dental health? Circle (worst) 1 2 3 4 5 6 7 8 9 10 (best)

Are you financially dependent on your dental insurance plan to pay for your dental needs ? [ ] Yes [ ]NO

Are you interested in applying for a monthly payment Plan (CareCredit)? [ ] Yes [ ] NO

How can we help you with your dental needs? Explain:
____
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Patient Appointment & Financial Policy

We want to provide you with the best care possible and will always do our best to help you understand your financial investment and maximize your insurance benefits. There may be services that are necessary for the treatment of your condition and maintenance of good health that are not covered by your dental insurance. Some services may be recommended for cosmetic or more personalized results which also may not be covered. After your initial examination, we will provide you with an individually tailored treatment plan and an estimate of your investment. Our Financial Coordinator will meet with you to explain your options, help you understand your insurance benefits, discuss available financing options and answer any questions you may have.

- Payment is due at the time of service. We accept cash, personal checks, and most major credit cards. We also offer several financing options to help you with your financial needs.
- All emergency dental services or any dental services performed without previous financial arrangements, must be paid at the time services are rendered.
- If you have insurance, we will submit claims on your behalf. Please understand, we cannot guarantee that your insurance will pay exactly as estimated. Coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility.
- You are responsible for all charges regardless of your insurance coverage.
- Deductible, co-payment, co-insurance and any non-covered service is due at the time of service.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form authorizes your insurance company to make payment directly to our office. By signing, you also authorize the release of any information concerning your treatment for the purpose of evaluating and administering claims for insurance benefits.
- The filing of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared by your carrier in 45 days, the unpaid portion will automatically become your responsibility and a statement will be issued to you for the unpaid portion. You are responsible for any amounts your insurance company chooses not to pay, for whatever reason.
- If for any reason my account becomes delinquent, I agree to pay all late charges, interest, collection fees, court costs and reasonable attorney/legal fees.
- Time, trained personnel, and dental equipment are reserved for each procedure. In order to provide the best services to our patients, we require at least a 24-hour notice for cancelling or for rescheduling your appointments. ***A fee will be charged for any appointment cancelled or rescheduled without a 24-hour notice*** **($50 for hygiene appointments and $125/hr for doctor appointments).**

I have read, understand and accept the financial and dental insurance policies listed above and have had any and all questions answered to my satisfaction. I agree to pay for all treatment as described. I hereby authorize my insurance benefits to be paid directly to McLemore Dentistry, LLC. I understand that most financial payment plans require a routine credit assessment and do hereby give my permission in order to help make my dentistry more affordable. I understand that I am financially responsible for any and all charges and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I hereby authorize the release of pertinent medical/dental information necessary to process claims, to the insurance company as required. This contract shall be governed by the laws of the State of Alabama. Venue shall be proper in Montgomery County, Montgomery, Alabama.

Signature of Patient, Parent, Guardian, or Responsible Party ____________ Date ____________

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Consent for Services

I understand that dentistry is not an exact science and no guarantees or assurance of the outcome or results of treatment or surgery can be made or implied. I understand that excessive smoking, alcohol, sugar, poor oral hygiene and not following my doctor's home care instructions may affect my healing and may limit the success of my dental treatment.

I request and authorize Dr. McLemore and/or staff to provide dental services and fully understand that during, and following the procedure, surgery, or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I agree to the type of anesthesia and/or sedation Dr. McLemore chooses, and agree not to operate a motor vehicle or hazardous device for at least 12 hours or more until fully recovered from the effects of sedation or the anesthesia or drugs given for my care.

I give my permission for any photographs, images, x-rays, or models to be taken and used by McLemore Dentistry, LLC for the advancement of dentistry or staff training purposes.

I agree that you may contact me by calling, sending text messages or email.

I hereby authorize any release of any information, including the diagnosis and records of treatment to my insurance company, or other doctor's offices as requested.

After an initial examination, a written estimate for the recommended dental treatment will be given, and financial arrangements along with risks, benefits and alternative treatments will be discussed at that time.

I have read, understand, and agree to the above conditions of treatment.

Signature of Patient, Parent, Guardian, or Responsible Party Date