MCCOLLUM DENTAL
FAMILY & COSMETIC DENTISTRY

Before Your First Visit

Please complete all fields marked with an asterisk (*). This information helps us provide you with personalized care.

Personal Information

First Name *

Middle Initial

Last Name *

Preferred Name

Date of Birth *

Marital Status

Social Security Number

Driver's License #

State

Contact Information

Street Address *

Apt/Suite

City *

State *

ZIP Code *

Email Address *

Mobile Phone *

Home / Work Phone

Emergency Contact

Name *

Relationship

Phone *

Referral & Appointment

How did you hear about us?

Reason for visit today *

Referred by (Name)

Previous dentist (if any)

Anything else we should know?

MCCOLLUM DENTAL
FAMILY & COSMETIC DENTISTRY

Insurance Information

We're happy to file your dental insurance claim for you. Please keep in mind that reimbursement depends on your individual plan and employer contract, so it can vary from patient to patient. Most plans have annual maximums (often $1,000-$1,500) and may not cover cosmetic treatments or pre-existing conditions. We ask that payment be made at the time of service, and your insurance will reimburse you directly afterward.

Do you have dental insurance?

- ◯ Yes
- ◯ No

Primary Insurance

Insured's Name

Insured's Date of Birth

Relationship to Patient

Insurance Company

Insured's Employer

Member/Policy ID#

Group #

Insurance Co. Phone #

Do you have additional dental insurance?

- ◯ Yes
- ◯ No

Secondary Insurance

Insured's Name

Insured's Date of Birth

Relationship to Patient

Insurance Company

Insured's Employer

MCCOLLUM DENTAL
FAMILY & COSMETIC DENTISTRY

Medical & Dental History

Your health history helps us provide safe, informed dental care. All information is strictly confidential.

General Health

Primary Care Physician

Physician Phone

Date of Last Physical

Currently under physician care? *

◯ Yes ◯ No

If under physician care, for what condition(s)?

Pregnant or possibly pregnant?

◯ Yes ◯ No ◯ N/A

Nursing?

◯ Yes ◯ No ◯ N/A

Take blood thinners (warfarin, Eliquis, Xarelto, aspirin, etc.)?

◯ Yes ◯ No

Taken bisphosphonates (Fosamax, Boniva, Zometa) in past 5 years?

◯ Yes ◯ No

Medical Conditions — Check All That Apply

- ☐ Heart disease / murmur
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pacemaker / defibrillator
- ☐ Stroke / TIA
- ☐ Thyroid disorder
- ☐ HIV / AIDS
- ☐ Osteoporosis
- ☐ Epilepsy / seizures
- ☐ Anemia / bleeding disorder
- ☐ Eating disorder
- ☐ Autoimmune condition
- ☐ Drug / alcohol dependency
- ☐ Sleep apnea / snoring
- ☐ Asthma / breathing issues
- ☐ Hepatitis (A, B, or C)
- ☐ Radiation / chemotherapy
- ☐ Joint replacement
- ☐ Acid Reflux / GERD
- ☐ Arthritis / joint problems
- ☐ Kidney / liver disease
- ☐ Cancer (active or past)
- ☐ Anxiety / depression
- ☐ Blood clotting disorder
- ☐ Tuberculosis (TB)
- ☐ Low blood pressure
- ☐ Diabetes (Type 1)
- ☐ Diabetes (Type 2)
- ☐ COPD / emphysema
- ☐ Other conditions not listed

Medications & Allergies

Current medications

Allergies (medications, latex, materials, foods)

Dental History

Dental history conditions — check all that apply

Date of last dental visit

- ☐ Dental anxiety
- ☐ Gum disease / perio treatment
- ☐ TMJ / Jaw Pain
- ☐ Dry mouth
- ☐ Orthodontic treatment (past or current)
- ☐ Bad experience with numbing (anesthetic)
- ☐ Cold/hot sensitivity
- ☐ Current tooth pain
- ☐ Teeth grinding / clenching
- ☐ Prior dental implants
- ☐ Dentures or partials

Current dental concerns or pain

Your Smile — Check Any That Apply

- ☐ I'd like my teeth to be whiter
- ☐ I'm unhappy with the size and shape of my teeth
- ☐ I hide my smile in photos
- ☐ I've been told I grind my teeth
- ☐ I'm interested in straightening my teeth
- ☐ I'd like to replace missing teeth
- ☐ I'm interested in learning more about veneers or bonding
- ☐ I'm happy with my smile as-is



Notice of Privacy Practices — Acknowledgment

Federal law requires us to provide you with our Notice of Privacy Practices and obtain your acknowledgment.

Notice of Privacy Practices — Summary

McCollum Dental ("Practice") is required by law to maintain the privacy of your protected health information (PHI) and to provide you with notice of our legal duties and privacy practices. A full copy of our Notice of Privacy Practices is available at the front desk and at mccollumdental.com.

How We Use Your Information

Treatment. We may use and disclose your PHI to provide, coordinate, or manage your dental care and related services, including sharing information with other health care providers involved in your treatment.

Payment. We may use and disclose your PHI to obtain payment for services, including insurance claims and billing activities.

Health Care Operations. We may use your PHI for quality assessment, training, and administrative purposes necessary to run the practice.

Your Rights

You have the right to: request restrictions on how we use or disclose your PHI; receive communications by alternative means or locations; inspect and copy your health records; request amendments; receive an accounting of disclosures; and file a complaint with the U.S. Department of Health and Human Services if you believe your rights have been violated.

Acknowledgment & Signature

By signing below, I acknowledge that I have received or been offered McCollum Dental’s Notice of Privacy Practices.

Patient or guardian signature *

Date Today (MM/DD/YYYY)

Signer's relationship to patient

Authorized to discuss my care (name)

Authorized Person's Relationship to Patient

MCCOLLUM DENTAL

FAMILY & COSMETIC DENTISTRY

Financial Policy & Agreement

Please review our financial policy and sign your agreement below.

Payment Policy

Payment is due at the time of service for all treatment. We accept cash, personal checks, all major credit cards, and CareCredit. Returned checks are subject to a $30 service fee.

As a courtesy, we file dental insurance claims on your behalf. However, reimbursement depends on your individual insurance plan, and any estimate we provide is not a guarantee of payment. You are responsible for your full balance regardless of your insurance company's determination.

We ask for at least 2 business days' notice for appointment cancellations or rescheduling. Missed or late-cancelled appointments are subject to a $50 fee.

Accounts not paid within 90 days will be charged a one-time $25 late fee.

You are responsible for any attorney or collection fees incurred if your account requires collection action.

Responsible Party

Complete this section only if someone other than the patient is financially responsible.

Responsible party name (if other than yourself)

Relationship to patient

Date of birth

Phone

Driver's License #

State

Social Security Number

Treatment Plans

We will present a written treatment plan with fees prior to beginning any elective or restorative treatment. Treatment plan fees are estimates and may vary based on clinical findings.

Minors

A parent or legal guardian must accompany patients under 18 and is financially responsible for all services rendered.

Agreement & Signature

☐ I have read and understand the financial policy above and agree to its terms. I authorize McCollum Dental to release necessary dental information to my insurance company for claims processing, and authorize direct payment of insurance benefits to McCollum Dental LLC.

Signature *

Relationship to patient (if other than yourself)

Date Today (MM/DD/YYYY)