Roy McCormick D.D.S.

First Name		Last Name	Marital Status	Height	Weight
Address	Apt #	City		State	Zip
Daytime Phone ( ) -	Evening Phone ( ) -	Cellular Phone ( ) -	Email		
Sex M ☐ F ☐	Age	Date of Birth / /	SSN	Drivers License	
Employer	Occupation	Address		Phone ( ) -	
Spouse/Parent's Name		Daytime phone			
Your Physician (MD)		Phone			
Emergency Contact		Phone			
Name of Dental Insurance/ Subscriber's Name				Patient's Relationship to Insured	
Policy Holder's Name (If Other Than Self)	Employer	Date of Birth / /	SSN		
Whom may we thank for referring you to our office					

Medical History

Have You Ever Had:	Yes	No
Heart Problems?	☐	☐
Heart attack or stroke?	☐	☐
Angina or chest pains?	☐	☐
Heart Surgery?	☐	☐
- Murmur?	☐	☐
Diabetes?	☐	☐
- Borderline or Diet Controlled?	☐	☐
- Insulin Dependant?	☐	☐
- Controlled Well?	☐	☐
High or low blood pressure?	☐	☐
Rheumatic fever?	☐	☐
Any prosthetic device?	☐	☐
Heart valve or Pacemaker?	☐	☐
Hip/other?	☐	☐
Prolonged bleeding problems?	☐	☐
Ulcers?	☐	☐
Cancer/chemo or radiation?	☐	☐
- Radiation to the head/neck?	☐	☐
Hepatitis or liver disease?	☐	☐
Asthma?	☐	☐
- Seasonal/easily controlled?	☐	☐
- Severe medication or inhaler?	☐	☐
Epilepsy/seizures/convulsions?	☐	☐
- Frequent or infrequent?	______________________	
- Controlled with medication?	☐	☐
Kidney or bladder problems?	☐	☐
Tuberculosis or emphysema?	☐	☐

	Yes	No
HIV?	☐	☐
Psychiatric treatment?	☐	☐
Smoke? Cigarettes/pipe/cigar?	☐	☐
How Much?	______________________	
Snuff or smokeless tobacco?	☐	☐
Are you taking any medications?	☐	☐

If so, please list:____

Do you have any disease or medical problem not listed above?

If so, please list:____

	Yes	No
Allergies or medications?	☐	☐

If so, please list:____

	Yes	No
Do you consider yourself in good health?	☐	☐

Reason for today's visit? ______________________________

____

Any concerns about your teeth?

If so, please list: _____________________________________

____

Females Only:

	Yes	No
Are you pregnant?	☐	☐
Taking birth control?	☐	☐
Had a hysterectomy?	☐	☐

____

Patient Signature Date

Roy McCormick D.D.S.

HIPPA Rights

Relationships are built on trust. One of the most important elements of trust is respect for an individual's privacy. The entire staff at Leander Dental Care values our relationship with you, and we take your personal privacy very seriously. This privacy notice explains how we manage the personal and health information used in administering your dental insurance. Please read this notice carefully.

Information We Collect About You

We collect nonpublic personal information about you or your family when you contact us to make a dental appointment. We require a copy of your insurance card and your drivers license and/or photo Identification. This personal information may include your name, address, telephone number, date of birth, Social Security number, and your employer information. We ask that you complete a comprehensive health history form for your personal record, as we require verification of your dental insurance for your specific plan coverage for you and all of your dependants.

How Your Information Is Used

The personal and health information we obtain and store is used to effectively administrate your insurance benefits and to protect your health needs. Upon arrival you will sign your first initial and last name on our sign in sheet. Part of your mane may be called if you are needed at the front desk or if you are being taken to the treatment area. Your personal health information may be discussed with your physician or another healthcare provider. Your personal information may be requested by your insurance company to provide them information to properly file a claim. A laboratory may require some of your personal information; however, this is usually limited in nature. Your treating dentist may discuss aspects of your case with one of his/her colleagues or information may be given to a specialist in order to provide treatment. The information you have provided to us may be used in the confirmation of appointments including messaged left on answering machines and/or voicemail.

Safeguarding Your Personal and Health Information

We restrict access to your personal and health information to those employees who need to know that information to provide services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your personal health information.

Changes to Our Privacy Policy

Leander Dental Care occasionally reviews its privacy policy and reserves the right to amend it. Should our privacy practices change, we will post a copy of the revised notice in our waiting area that indicates the date of the amend notice. You may request and obtain a copy of our Notice of Privacy Practices anytime you visit our office.

Cancellation Policy

Please provide 24-hour notice for all cancellations. There will be a $35.00 fee for all missed weekday appointments, and $50.00 for missed Saturday appointments.

I have read and understand the above Privacy Notice for Leander Dental Care.

____ ____/____/____

Patient if over 18 or Parent/Guardian Date