J SCOTT MAHANEY, DDS
FAMILY & COSMETIC DENTISTRY

Date: ____/____/____ **Patient Information** Social Security#____-____-____

Patient name:_____ Gender____ Birthdate____/____/____ Age:____
Last, First Preferred Name

Address:_____ City:_____ State:____ Zip:_____

Phone: Home:_____ Cell:_____ Work:_____ (ext)_____

Email Address:_____

If you are a new patient, how were you referred to our office?

_____Phone Book _____Website _____Newspaper _____Relative _____Friend

Name of person who referred you to our office:_____

Insurance Information & Authorization

We welcome the opportunity to assist you with your dental insurance.

If we are filing your claim for you, it is important that you understand we will be estimating your portion according to the general information given to us by your insurance company. This portion is due at the time of service.

Once a claim is filled, actual benefits are determined by your insurance carrier. If there is a remaining balance on your account after insurance completes payment, you are financially responsible for that balance. That balance will be due immediately upon receiving notification from our office.

Please Check:

- ☐ I authorize payment of benefits directly to the provider.
- ☐ I authorize the release of all necessary information to the insurance carrier and their representatives.
- ☐ I have read this form and agree to be financially responsible for any balance remaining on my account.

Consent For Services

Please Check:

- ☐ I authorize Dr. Mahaney to take radiographs, study models, photographs and/or any other diagnostic aids deemed appropriate. I also authorize Dr. Mahaney to prescribe any and all forms of medication and perform any treatment that may be indicated and agreed upon.
- ☐ I understand that photographs may be used as a record of my care and/or utilized for case studies in the office or on the office website. At no time will your personal information or identity be disclosed.
- ☐ I am aware that Dr. Mahaney follows the protocol of HIPAA's notice of privacy laws and I have been offered a copy of these laws.
- ☐ I agree to be financially responsible for any balance on my account.

_____ _____ _____-_____-_____
Signature of patient, parent or guardian Relationship to Patient Date

8209 Genoa Ave ◆ Lubbock, Tx 79424 ◆ (806) 319-9500
yourlubbockdentist.com

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HEALTH INFORMATION

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- ☐Y ☐N **AIDS / HIV**
- ☐Y ☐N **Alcoholism**
- ☐Y ☐N **Anemia**
- ☐Y ☐N **Arthritis**
- ☐Y ☐N **Artificial Joints**
- ☐Y ☐N **Asthma**
- ☐Y ☐N **Blood Disorders**
- ☐Y ☐N **Cancer**
- ☐Y ☐N **Colitis**
- ☐Y ☐N **Diabetes**
- ☐Y ☐N **Drug Dependency**
- ☐Y ☐N **Epilepsy**
- ☐Y ☐N **Excessive Bleeding**
- ☐Y ☐N **Glaucoma**
- ☐Y ☐N **Head Injuries**
- ☐Y ☐N **Heart Disease**
- ☐Y ☐N **Heart Murmur**
- ☐Y ☐N **Hepatitis A, B or C**
- ☐Y ☐N **High Blood Pressure**
- ☐Y ☐N **Jaundice**
- ☐Y ☐N **Kidney Disease**
- ☐Y ☐N **Liver Disease**
- ☐Y ☐N **Mental Disorder**
- ☐Y ☐N **Osteoporosis**
- ☐Y ☐N **Pacemaker**
- ☐Y ☐N **Radiation Treatment**
- ☐Y ☐N **Respiratory Problems**
- ☐Y ☐N **Rheumatic Fever**
- ☐Y ☐N **Stomach Ulcers**
- ☐Y ☐N **Stroke**
- ☐Y ☐N **Tuberculosis**

ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING:

- ☐Y ☐N **Antibiotics**
- ☐Y ☐N **Blood Thinners** (Coumadin, Plavix)
- ☐Y ☐N **Bisphosphonates** (Fosamax, Actonel, Boniva, Reclast or chemotherapy for breast cancer, multiple myeloma)
- ☐Y ☐N **Insulin**
- ☐Y ☐N **Pain Medications**

Please list any other medications you are currently taking and what it is for:

Medication:	**For:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HAVE YOU EVER HAD AN ALLERGIC REACTION TO:

- ☐Y ☐N **Latex**
- ☐Y ☐N **Penicillin**
- ☐Y ☐N **Sulfa Drugs**
- ☐Y ☐N **Aspirin**
- ☐Y ☐N **Ibuprofen**
- ☐Y ☐N **Codeine**
- ☐Y ☐N **Sedatives**
- ☐Y ☐N **Local Anesthetics**
- ☐Y ☐N **Epinephrin**

Other allergic reactions, please list:

_____
_____
_____
_____
_____

OTHER INFORMATION

☐Y ☐N **Do you smoke, chew or dip tobacco? If yes, how much per day:**_____

☐Y ☐N **Are you under the care of a physician(s)?**
Name of Physician:_____ Phone #:_____
_____ _____
_____ _____

☐Y ☐N **Have you ever had any serious illness, operations, or hospitalization?**
If yes, please describe and dates: _____
_____

☐Y ☐N **Do you have any health problems that aren't mentioned above or that need further clarification?**
If yes, please describe: _____
_____
_____

DENTAL HISTORY

☐Y ☐N Are you happy with your smile?

☐Y ☐N Is there anything you would like to change about your smile?
If so, please describe: _____

☐Y ☐N Do your gums bleed?

☐Y ☐N Do you suffer from bad breath?

☐Y ☐N Do you grind or clench your teeth?

FOR WOMEN ONLY

☐Y ☐N Are you pregnant or is there any chance you might be pregnant?
If yes, due date: _____

☐Y ☐N Are you nursing?

☐Y ☐N Do you understand that taking antibiotics may interfere with the effectiveness of oral contraceptives (birth control)? Alternative methods of birth control should be considered while taking antibiotics.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform this office of any changes at the next appointment.

_____ _____ /_____ /_____
Printed Name of Patient **Patient's Date of Birth**

_____ _____ _____ /_____ /_____
Signature of patient, parent or guardian **If Patient is a minor, Relationship to Patient** **Today's Date**

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Office Policies and Financial Agreement

It is our desire to provide the highest quality dental care to everyone. The following is a statement of Dr. Scott Mahaney's Dental/Financial Policies. We ask that you please read, agree to, and sign before any treatment is rendered.

Regarding Insurance
Our goal to maximize your insurance benefits. It is important to understand that the insurance contract is between your insurance company and you, the insured. Dental insurance was not designed to pay for all dental care. Treatment recommended by Dr. Mahaney and his associates is never based on what your insurance company will pay. Due to pending claims and patient privacy issues, we do not always know how much an insurance company has already paid to another office or specialist, and the balance remaining on a yearly maximum.

Please be prepared to show your insurance card at the time of your visit. It is the patient's/guarantor's responsibility to provide any new information regarding insurance. Our office will gladly submit your insurance claim to your insurance carrier, as a courtesy to you. At the time of treatment, the patient/guarantor is responsible for the estimated portion the insurance does not cover. If for some unforeseen reason your insurance carrier has denied or not made payment within 60 days, the patient/guarantor is responsible for the balance in full. _____ (Initial)

Payment Options
Cash, Check, MasterCard, Visa, American Express, or Discover

3rd Party Financing (Office Payment Plan)
With prior approval, we are pleased to offer a choice of No Interest or Extended Payment Plans to qualified applicants through Care Credit. If you would like to make extended payments for services at our office, please ask any of our administrative team for assistance in filling out an application form.
_____(Initial)

Additional Charges
A fee of $30 will be charged on all returned checks. _____(Initial)

Cancellation Policy
If you are unable to keep an appointment, we ask that you kindly provide us with the minimum of a 24 hour notice; otherwise there will be a $25 broken appointment fee. Our office does not accept cancellation or changes in appointments after hours by voice mail or Demand Force; you **must** call during our normal business hours. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist. _____(Initial)

Office Hours:
Monday- Thursday 8:00AM - 5:00PM
Friday: Office Closed

_____
PATIENT NAME

_____ _____
PATIENT SIGNATURE **DATE**
(PARENT/GUARANTOR signature if Patient is a Minor)