GLENN A.
MacFarlane, DMD

Date: _____

Patient Information

Patient Name: _____
(Last) (First) (Middle Initial)

Sex: M/F Date of Birth: _____ SSN#: _____ Marital Status: _____

Home Telephone: _____ Cell Phone: _____ Work: _____

Home Address: _____
(Street or P.O Box)

_____
(City) (State) (Zip Code)

Patient's Employer: _____ *Email Address*: _____

Emergency Contact Name: _____ Phone#: _____

Spouse's Name: _____Phone #: _____

Name of nearest relative/friend not living with you: _____Phone #: _____

How did you hear about our office? _____

Billing Information

Person Responsible for Bill: _____
(Last) (First) (Middle Initial)

Responsible Party's Home Telephone: _____ Cell: _____

SSN#: _____ Date of Birth: _____

Responsible Party's Address: _____
(Street or P.O Box)

_____
(City) (State) (Zip Code)

Responsible Party's Employer: _____Business Telephone: _____

Is insured a current patient? Y/N

Name of Insured: _____
(Last) (First) (Middle Initial)

Employer: _____SSN#: _____Date of Birth: _____

Name of Insurance Company: _____

Group number: _____Telephone Number of Insurance Company: _____

_____***Initials*** ***CANCELLATION POLICY***: *As a courtesy to other patients, all cancellations must be made* ***24 hours*** *in advance of any scheduled appointments. If cancellations occur after this time, your account may be charged a cancellation fee. If you do not show for your scheduled appointment, your account may be charge a* ***"No-Show"*** *fee.*

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Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Family physicians name: _____

Are you under a physician's care now ☐ Yes ☐ No Physicians name:_____

Have you ever been hospitalized or had a major operation ☐ Yes ☐ No_____

Have you had an orthopedic total joint replacement: ☐ Yes ☐ No_____

Do you use tobacco ☐ Yes ☐ No _____

Do you use controlled substances ☐Yes ☐ No _____

Women: Are you ☐Pregnant/Trying to get pregnant ☐Nursing ☐Taking Oral Contraceptives

Are you previously or currently taking Bone metabolism medications ☐Yes ☐No (Examples: Actonel, Zometa, Boniva, Fosamax):_____

Are you taking asprin ☐Yes ☐No

Please list all medications you are currently taking: _____

_____

_____

Are you allergic to any of the following? **(Please Circle)**

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
Other: Please List _____

Do you have or have had, any of the following? **(Please Circle)**

AIDS/HIV Positive	Chest Pain	Frequent Headaches	Irregular Heartbeat	Scarlet Fever
Alzheimer's Disease	Cold Sores/Fever Blisters	Genital Herpes	Kidney Problems	Shingles
Anaphylaxis	Congenital heart Disorder	Glaucoma	Leukemia	Sickle Cell Disease
Anemia	Convulsions	Hay Fever	Liver Disease	Sinus Trouble
Angina	Cortisone Medicine	Heart Attack/Failure	Low Blood Pressure	Spinal Bifida
Arthritis/Gout	Diabetes	Heart Murmur*	Lung Disease	Stomach/Intestinal Disease
Artificial Heart Valve*	Drug Addiction	Heart Pace Maker*	Mitral Valve Prolapse*	Stroke
Artificial Joint*	Easily Winded	Heart Trouble/Disease	Pain in Jaw Joints	Swelling of Limbs
Asthma	Emphysema	Hemophilia	Parathyroid Disease	Thyroid Disease
Blood Disease	Epilepsy/Seizures	Hepatitis A	Psychiatric Care	Tonsillitis
Blood Transfusion	Excessive Bleeding	Hepatitis B/C	Radiation Treatments	Tuberculosis
Breathing problem	Excessive Thirst	Herpes	Recent Weight Loss	Tumors/Growth
Bruise Easily	Fainting Spells/ Dizziness	High Blood Pressure	Renal Dialysis	Ulcers
Cancer	Frequent Cough	Hives/Rash	Rheumatic Fever*	Venereal Disease
Chemotherapy	Frequent Diarrhea	Hypoglycemia	Rheumatism	Yellow Jaundice

****conditions may require medication***

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐Yes ☐No

Have you ever had any serious illness not listed above: ☐Yes ☐No ☐ N/A: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the Patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

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Dental History

- When was the last time you saw a dentist? _____
- What was done at that time? _____
- What it the reason for your visit today? _____
- Have you ever been treated for periodontal disease? ☐ Yes ☐ No
- Have you had braces before? ☐ Yes ☐ No
- Does dental treatment make you nervous? ☐ Yes ☐ No
- Have you had an unpleasant dental experience? ☐ Yes ☐ No
- How often do you floss? _____
- What type of toothbrush do you use? (circle one) Soft Medium Hard Electric
- What other cleaning aids, devices or rinses do you use? _____
- Were dental X-Rays taken? _____ YES or NO
- Have you lost any teeth or have any teeth been removed? _____ YES or NO
- Have they been replaced? _____ YES or NO
    - Fixed Bridge _____ Age _____
    - Removable Bridge_____ Age_____
    - Denture_____ Age_____
    - Implant _____ Age_____
- Are you unhappy with the replacement? _____ YES or NO
- Would you like to know about permanent replacements? _____YES or NO
- Have you lost any teeth or have any teeth been removed ☐ Yes ☐ No
- Previous dentists name _____

Do you experience any of the following?

- Bleeding or sore gums ☐ Yes ☐ No
- Bad breath/ unpleasant taste ☐ Yes ☐ No
- Tingling or burning tongue or lips ☐ Yes ☐ No
- Swelling or lumps in mouth ☐ Yes ☐ No
- Sores in mouth ☐ Yes ☐ No
- Food trapping between teeth ☐ Yes ☐ No
- Trouble swallowing without water ☐ Yes ☐ No
- Loose teeth ☐ Yes ☐ No
- Sensitive to hot ☐ Yes ☐ No
- Sensitive to cold ☐ Yes ☐ No
- Sensitive to sweets ☐ Yes ☐ No
- Clicking or popping jaw ☐ Yes ☐ No
- Frequent headaches ☐ Yes ☐ No
- Grinding or clenching ☐ Yes ☐ No

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Patient Smile Evaluation Form

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions. Please circle your answer.

Do you dislike the color of your teeth?	YES NO
Do you have spaces between your teeth that bother you?	YES NO
Do you have chips or uneven edges on your teeth?	YES NO
Do you feel that your teeth are too long or too short?	YES NO
Do you have dark fillings that show when you smile?	YES NO
Do your gums show too much when you smile?	YES NO
Are your teeth crowded or crooked?	YES NO
Do you have existing crowns or dental work you consider "ugly"?	YES NO
Are you self-conscious of your teeth and/or smile?	YES NO
Has anyone (family member, friend, etc.) ever suggested that you should have something done with your teeth or smile?	YES NO
Do you avoid smiling when you have your picture taken?	YES NO
Would you like to improve your existing smile?	YES NO
Do you wish you had a "new smile"?	YES NO

Place a checkmark next to which of the following are concerns you have regarding dental treatment to improve your smile:

Fear of treatment
Time of treatment
Financial Concerns
Distance to Office
Understanding Treatment
Embarrassment
Other

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The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (eg. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

1 - 6	Congratulations, you are getting enough sleep!
7 - 8	Your score is average
9 and up	Seek the advice of a sleep specialist without delay

If your score is greater than 6 points then you are sleepy. If your score is more than 10 points you are very sleepy. If your score is more than 16 points you are dangerously sleepy. If your score doesn't improve after 2 weeks of 8 hours of sleep a night, it is recommended that you consult your doctor.

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Oral Cancer

Oral Cancer is on the rise, and last year 34,000 Americans were diagnosed with oral or pharyngeal cancer. On average it will cause over 8,000 deaths, killing 1 person per hour, 24 hours a day. Of those 34,000 newly diagnosed individuals, only half will survive 5 years. The death rate of oral cancer is higher than that of other cancers which we hear about routinely such as cervical cancer, Hodgkin's lymphoma, laryngeal cancer, cancer of the testes, even in skin cancer.

The diagnosis of oral cancer is also directly related to the human papilloma virus, affecting 50% of those diagnosed with HPV. HPV has the potential to cause an abnormal growth on a particular part of your body including lesions in your mouth and upper respiratory system.

The alarming mortality rate associated with this disease is due to the lack of early detection. If oral cancer is detected early it is completely treatable.

The good news is we can detect the early signs of oral cancer with a Oral ID oral cancer screening today. It is pain-free and only takes a few minutes. It is the best tool we have to help detect the early signs of oral cancer. The cost for this service is **$35.00** and may be covered by your insurance company. Please initial below:

_____ I have been informed regarding the risk of oral cancer and I wish to have the Oral ID oral cancer screening today.

_____ I have been informed regarding the risk of oral cancer but I do NOT wish to have the Oral ID oral cancer screening today. I assume all risk associated with the unforeseen diagnoses of oral cancer.

Broken Appointments

For any appointment cancelled less than 24 hours prior, or a no show, the patient will be charged $75.00 per half hour of scheduled time. Validated medical excuses are excluded. Fees will be charged to the card on file.

_____ _____

Signature Date

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Glenn A. MacFarlane, D.M.D. Office and Financial Policies

This is an outline of our office financial policies. We ask that you provide any/all insurance information to us upon arrival of your first visit. While we will do our very best to outline your insurance plan to you***, it is ultimately your responsibility to know your insurance plan benefits and restrictions*.** Based upon the information given to us by your insurance plan, we will ask for co-payments accordingly. It is important to remember that your insurance policy is a contract ***between you and your insurance company***. We will do everything possible to assist you in getting your claim paid: however, all charges incurred for your dental treatment are ***your sole financial responsibility***. Your co-payments are an estimate only. The quotes given to our office by your insurance company are merely that. ***They are not a guarantee of payment to us***. Your co-payment, deductible, or any balances are due at the time services are rendered. If you are unable to pay your estimated portion at that time, we ask that you make prior financial arrangements with our billing representative or through our other payment options. **All** patients who assign insurance benefits to us must complete the credit card form on the next page. Please read it carefully before signing.

If you do not have dental insurance, by signing this statement you acknowledge that you understand you are responsible for payment in full at the time services are rendered. If you have insurance, by signing this statement you acknowledge that your insurance company may pay less than the actual bill for services and that you are fully responsible for payment of your account. By signing this statement you agree to pay for all balances not paid by your insurance company and any legal fees incurred to enforce this statement. ***** Please see below**. Finance charges can be applied to all amounts that are at least 30 days past due at the rate of **1.5%** per month (**18%** annual rate). **If the account is in default and turned over for collection, I acknowledge that I will be responsible for all reasonable costs associated with effecting collection.** If during the admission or application process I have provided a cell phone number; I acknowledge that I may be contacted at that number for account servicing matters, including but not limited to, collecting on my account should it become delinquent.

I hereby authorize the release of any information relating to insurance claims and I authorize payment of my group benefits directly to Glenn A. MacFarlane, D.M.D. and MacFarlane Dental Associates, LLC. I agree to give Glenn A. MacFarlane, D.M.D. permission to contact me regarding appointments and/or treatment at the phone number provided. I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.
I certify that the information I provided here is true and correct.

Signature: _____ Date: _____

***** A valid credit card (not debit card) must be left on file. Please provide that information on the following page. A copy of your card is required. We also require a copy of a valid driver's license.**

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Glenn A. MacFarlane, D.M.D.
211 Broad Street, Suite 106
Red Bank, NJ 07701
732-530-4020
drglennmacfarlane.com

Patient Name: _____

Cardholder's Name: _____

Address: _____

Phone: _____ Relationship to patient: _____

I , _____, hereby authorize Glenn A. MacFarlane, D.M.D. to charge my:

Visa Account #:_____ Exp. date:_____ Sec. Code:____

MasterCard Account #:_____ Exp.date:_____ Sec. Code:____

Discover Account #: _____ Exp. date:_____ Sec. Code:____

Amex Account #: _____ Exp. date:_____ Sec. Code:____

Your card will be charged for insurance copayments at the time of service, for any balance owing after receiving your final insurance payments, and for any insurance payments not received within 30 days of the date of service**. Any credit remaining on your account, after all insurance payments have been made, will be returned back to your card. I further understand that this form will be attached to my permanent records and can be used for all future treatment. I also understand that this form will not be viewed by any person not employed by this office.

Signature: _____

Print Name: _____

Date: _____

****Final insurance reimbursements not received within 30 days of the completion of services will have all fees owing up to that final date of the service charged to your card.**

There are NO EXCEPTIONS.

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Glenn A. MacFarlane, D.M.D.
211 Broad Street Suite 106
Red Bank, NJ 07701
drglennmacfarlane.com

Authorization Form

Patient Authorization for Use and Disclosure of Protected Health Information.

By signing, I authorize **Glenn A. MacFarlane, D.M.D.** to use and/or disclose certain protected health information (PHI) about me to my insurance carrier by postal mail or electronic mail.

PLEASE BE FAMILIAR WITH THE NOTICE OF PRIVACY PRACTICES

This information will be used or disclosed solely for the reimbursement from the insurance carrier for services performed by **Glenn A. MacFarlane, D.M.D.** This authorization will not expire unless revoked in writing to **Glenn A. MacFarlane, D.M.D. at the above address.**

The Practice will ___ will not **_X**__ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **Glenn A. MacFarlane, D.M.D.**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer: **Glenn A. MacFarlane, D.M.D. at the above address.**

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

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Glenn A. MacFarlane, D.M.D.
211 Broad Street Suite 106
Red Bank, N.J. 07701
732-530-4020
drglennmacfarlane.com

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give consent for **Glenn A. MacFarlane, D.M.D.** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by **Glenn A. MacFarlane, D.M.D** describes such uses and discloses more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Glenn A. MacFarlane, D.M.D** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Glenn A. MacFarlane, D.M.D./Officer**

With this consent, **Glenn A. MacFarlane, D.M.D** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Glenn A. MacFarlane, D.M.D** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Glenn A. MacFarlane, D.M.D** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Glenn A. MacFarlane, D.M.D** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Glenn A. MacFarlane, D.M.D** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Glenn A. MacFarlane, D.M.D** may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____

Print Name of Patient or Legal Guardian | Date

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Glenn A. MacFarlane, D.M.D. – Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information

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Our legal duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, out legal duties and your rights concerning your health information. We must follow the privacy practices that are described in the notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made changes. Before we make significant change in our privacy practices, we will change this notice and make the new notice available.

Uses and disclosures of health information: We use and disclose health information about you for treatment payment, and healthcare operations.

***Patient Rights*: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request, unless we cannot practically do so. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $25 administration fee plus $5 per page for records.**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date: _____

Employee Signature: _____

GLENN A.
MacFarlane, DMD

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Red Bank, N.J. 07701
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drglennmacfarlane@gmail.com
www.drglennmacfarlane.com