Dr. James McLain

Today's Date: _____

Patient Name: _____
Last Name First Preferred Name

Address: _____

City: _____ **State**: _____ **Zip**: _____

Gender: MALE ◯ FEMALE ◯ **Birth Date**: _____

Family Status: MARRIED ◯ SINGLE ◯ CHILD ◯ OTHER ◯

Phone Number: _____ **Home** ◯ **Cell** ◯ **Work** ◯

Phone Number: _____ **Home** ◯ **Cell** ◯ **Work** ◯

Social Security # _____ **Drivers License #** _____

Email Address: _____

Employer: _____

Employer's Address: _____
Phone

REFERRED BY: _____

Please continue to Page 2

ACCOUNT INFORMATION:

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____
Last Name First Name

Address: _____

_____

Phone: _____ Home ◯ Cell ◯ Work ◯

Dental Insurance Company: _____

ID#:_____**Group#**_____**Phone#**_____

Policy Holder:_____ **Policy Holder DOB:**_____

In the event of an Emergency, whom do we contact?

Name: _____ **Relationship:**_____

Phone #: _____

Who is your medical Doctor? _____

Medical Doctor Phone Number: _____

Please continue to Page 3

General Consent

Thank you for choosing our office for your dental care. We will work with you to help achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include relief of pain, the ability to chew properly and the confidence with social interaction that a pleasant smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical reaction**. Dental materials and medications may trigger allergic or sensitivity reactions.
2. **Long term numbness (paresthesia).** Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or joint tenderness.** Holding one's mouth open can result in muscle or jaw tenderness, or in predisposed patient, precipitate a TMJ disorder.
4. **Sensitivity in teeth or gums, infection or bleeding.**
5. **Swallowing or inhaling small objects.**

While we follow procedural guidelines which most often lead to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does.

Please feel free to ask questions in regards to all dental procedures that are recommended to you.

_____ _____

Patient Signature or Parent/ Guardian Signature Date

Appointment & Financial Policy

Please be aware that charges incurred for treatment provided are your responsibility regardless of any expected insurance coverage. Dental insurance is a benefit used to assist you with the cost of necessary dental expenses and should neither dictate nor prohibit treatment. As we work with you to reach your optimum oral health, **we require that your estimated co-payment for treatment be paid at the time treatment is rendered**.

As a courtesy to you, we will submit claims to your insurance on your behalf. However, it is important that you understand that the agreement regarding your dental insurance and dental benefits is between you, your employer, and your insurance company. Although we are willing to submit dental claims on your behalf, you are financially responsible for the services rendered in our office.

Downing Street Dental accepts payment in the form of cash, personal check, Discover, MasterCard, Visa and CareCredit. Returned checks will be subjected to bank fees and/or finance charges at the rate of 1.5% per month (18% annually).

We strive to keep all financial arrangements and accounts in house. However, account balances left unpaid for 90 days or more may be sent to a third party collection agency. You are responsible to pay all costs of collections including, but not limited to; collection fees, attorney fees, and interest.

Please keep in mind that we have reserved time in our schedule especially for you. We urge you to keep your appointments, due to limited time and space. **If you need to cancel or reschedule your appointment, please give us at least 48 hours notice**, so that we may offer your reserved time to another patient. **If we do not receive the required notice to cancel or reschedule an appointment, you will be charged a $50.00 broken appointment fee.**

I have read, understand, and accept the terms and conditions of this policy.

Printed Name of Patient	Signature of Patient	Date

Dental Treatment Consent and Affirmation Form
COVID-19 Reopening

1. I knowingly and willingly consent to dental treatment at Downing Street Dental by Dr. James McLain and any designated associates and employees during the reopening phase of COVID-19.
2. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms yet are still highly contagious. It is impossible to determine who has COVID-19 and who does not given the current limitations and availability in COVID-19 viral testing.
3. Risk of transmission: I understand that due to the frequency of visits of other care dental patients, characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office, even though standard precautions are being observed.
4. I am unaware of being a possible carrier or infected: I confirm that I have not tested positive for COVID-19 in the last 30 days and that I am not presenting with any of the following symptoms of COVID-19:
    A. Fever of 100.5 degrees Fahrenheit or 37 degrees Celsius or higher
    B. Shortness of breath
    C. Dry cough
    D. Runny nose
    E. Sore throat.
    F. Diminished sense of taste or smell
5. Contact with infected: I confirm that I have not knowingly been in close contact (defined as 6 feet or less for a duration of fifteen minutes or more) with someone who has tested positive for COVID-19 in the last 14 days, or with anyone that has had the above stated symptoms in paragraph 4 (#4) in the last 14 days.
6. Public travel: I confirm that I have not traveled outside of the United States in the past 14 days. I confirm that I have not traveled domestically by commercial airline, bus, or train within the last 14 days.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the risks of contracting COVID-19 from the dental office and dental procedures. I reaffirm that I am not a carrier of COVID-19 nor infected with COVID-19 to the best of my knowledge. I voluntarily assume any and all medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of my treatment as a result of the COVID-19 pandemic. I acknowledge that the nature and purpose of the dental procedures recommended under the current circumstances and restrictions have been explained to me and that I have been given the opportunity to ask questions.

_____ _____

Patient's name (please print) Signature of patient, guardian or authorized representative

_____ _____

Witness to signature Date

COVID-19 PANDEMIC - PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions during the COVID-19 virus outbreak

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	**No**
Do you have a fever or above normal temperature?		
Have you experienced shortness of breath or had trouble breathing?		
Do you have a dry cough?		
Do you have a runny nose?		
Have you recently lost or had a reduction in your sense taste or smell?		
Do you have a sore throat?		
Have you been in contact with someone who has tested positive for COVID-19?		
Have you tested positive for COVID-19?		
Have you been tested for COVID-19 and are awaiting results?		
Have you traveled outside the United States by air or cruise ship in the past 14 days?		
Have you traveled within the United States by air, bus or train within the past 14 days?		

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Signature Date

_____

Witness