Shawn R. McDevitt, DDS
Dentistry for Adults and Children

CLIENT MEDICAL HISTORY

PATIENT NAME_____Date of Birth_____

Date of last dental visit_____ Name of previous Dentist_____ City_____State_____
What dental concerns are you now having?_____

1. Are you in good health?.....YES/NO
2. Are you pregnant or thinking you might be?.....(due date_____).....YES/NO
3. Are you now or have you been under the care of a physician during the past year? .....YES/NO
   If yes, what condition?_____

Are you presently taking any medications, including birth control? If so, name of RX/mg/condition being treated:

a) _____mg/dosage_____reason_____
b) _____mg/dosage_____reason_____
c) _____mg/dosage_____reason_____
d) _____mg/dosage_____reason_____

Have you ever had any major injuries, illnesses, operations or medical conditions.....YES/NO

a) _____when_____
b) _____when_____
c) _____when_____

Have you ever had prolonged bleeding requiring treatment or are you on blood thinners?.....YES/NO
Have you ever taken Bisphosphates (Fosamax, Actonel, Boniva, ect.) Tx for osteoporosis or cancer....YES/NO
Circle any of the following for which you have been treated:

a)	artificial heart valve	YES/NO	l)	high blood pressure	YES/NO
b)	asthma	YES/NO	m)	joint replacement	YES/NO
c)	cancer, especially of head/neck	Yes/NO	n)	kidney liver involvement	YES/NO
d)	diabetes	YES/NO	o)	nervousness, fainting, dizziness, depression	YES/NO
e)	emphysema	YES/NO	p)	other heart conditions	YES/NO
f)	epilepsy/convulsions	YES/NO	q)	rheumatic fever – heart murmur	YES/NO
g)	exposure to AIDS virus	YES/NO	r)	sexually transmitted disease	YES/NO
h)	Glaucoma	YES/NO	s)	stomach problems	YES/NO
i)	hay fever/ sinus condition	YES/NO	t)	thyroid	YES/NO
j)	headaches	YES/NO	u)	tuberculosis	YES/NO
k)	hepatitis-serum or infectious	YES/NO	**NONE OF THE ABOVE**_____		

Circle any of the following if they have caused an unusual reaction and list all the known allergic reactions:

WHAT WAS THE REACTION?

a. Aspirin, Ibuprofen, or Tylenol _____
b. Penicillin or other antibiotic _____
c. Dental anesthetic......_____
d. Codeine, valium, or other sedatives_____
e. Latex or rubber product.....,_____
f. Metals (gold/nickel/silver).....,_____
g. Other allergies.....,_____

NO KNOWN ALLERGIES_____

Do you use tobacco? YES/NO If yes, circle type: smoke chew how much per day_____ for how long_____
Do you vape? YES/NO Do you use Marijuana? YES/NO How often? _____
Have you ever experienced any unfavorable reaction from previous dental treatment.....YES/NO
If yes, please explain_____
Is your child receiving fluoride supplements?.....YES/NO
What physician or hospital may we call in a medical emergency?_____
Emergency contact person (relationship) _____phone number_____

Signature_____ Date_____

Shawn R. McDevitt, DDS
Dentistry for Adults and Children

307 South 11th Avenue
Yakima, WA 98902
(509) 453-5568
sh.awnmcdevittdds@gmail.com

Name: _____ Birthdate: _____

Address: _____ Phone: _____

City, State, Zip: _____ Cell Phone: _____

E-Mail: _____ Best Day time phone: _____

Single____ Married ____ Widowed ____ Divorced ____

Name of spouse/parent/guardian: _____
(please circle one)

Your/parent Employer: _____ Occupation _____ Phone _____

Spouse/Parent Employer _____ Occupation _____ Phone _____

Person Responsible for account _____

Address: _____ Phone _____

City, State, Zip _____ Cell phone _____

Person To contact in case of emergency _____ Phone number _____

Whom may we thank for referring you to our office? _____

Date of last dental visit: _____ Name of previous Dentist _____

What dental problems are you now having? _____

_____

_____

Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?

_____

_____

Insurance Information

Primary Insurance Holder: _____ **Birthdate** _____

Employer: _____ **Insurance Company:** _____

Identification # _____ **Toll Free phone #** _____

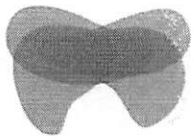
Social Security number _____ **Group number** _____ **Plan ID** _____

Secondary Insurance Holder: _____ **Birthdate** _____

Employer: _____ **Insurance Company:** _____

Identification # _____ **Toll Free phone #** _____

Social Security number _____ **Group number** _____ **Plan ID** _____



Shawn R. McDevitt, DDS

Dentistry for Adults and Children

Date: _____

I authorize:

_____

_____

_____

To release dental x-rays/information for the purpose of further dental treatment to:

Shawn R. McDevitt, DDS
307 South 11th Avenue
Yakima, w98902
(509) 453-5568 (509) 972-6623 Fax

e-mail: SHAWNMCDEVITT@SHAWNMCDEVITTDDS.COM (for digital xrays)

X-Ray/information requested: Most recent Pano/FMX (even if not current). BWX and perio charting

Client name: _____
Birthdate: _____
Address: _____

_____

_____

Client Signature: _____

Our goal is to provide excellent Dental care to our community in as cost effective manner as possible. Realizing the dental insurance landscape is complex and ever changing we strive to assist our clients in making the best use of your individual dental insurance benefits. The majority of Dental insurance companies continue to have a maximum benefit of $1000.000 - $1500.00 annually. The dental insurance benefit maximum has remained at this level for decades. However costs of dentistry have not remained static and out of pocket expenses have increased for our clients. At this time we are communicating to all of our clients the payment plans and financial policy of our dental office as we attempt to provide multiple options for our clients to finance their dental health needs.

It is our goal to work with all of our clients to develop payment plans that meet the needs of your budget with the costs associated with providing quality dental care.

Financial Policy – Shawn R. McDevitt, DDS

Providing our clients with comprehensive dental care is our goal. We strive to provide dental care in a professional, friendly, caring environment. We will work with our clients to provide financial arrangements, enabling you to obtain necessary services while working within your budget.

Dental Insurance

Dr. McDevitt will diagnose treatment based on your dental health not your insurance coverage

As a courtesy we will file your claims and accept assignment of dental insurance benefits. We will help you to receive your maximum allowable benefits. In order to do this we need a copy of your current insurance card. We ask that you inform us ahead of your appointment if your insurance has changed since your last visit.

- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you; not your insurance company.
- We will do our best to estimate your insurance. Knowledge of your benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is your responsibility. Receiving our services indicates your acceptance of responsibility to pay
- There are multiple factors in determining patient responsibility where coordination of benefits between two insurance companies is involved. We will provide you with the most accurate information available to us but cannot guarantee what your out of pocket expense will be.
- Please understand that our responsibility is to provide you with treatment that best meets your needs, not to try to match your care to insurance plan limitations

Payment policy:

- At each visit we ask that you make full payment unless other arrangements have been made. If you have dental insurance, we ask that you pay that portion which your insurance does not pay
- We accept cash, personal checks, debit cards, Visa, MasterCard, Discover, and American Express
- Financing through Care Credit with prior approval
- If there is a balance and the charges have been on the account for over 90 days interest of 1% per month (12% per year) will be assessed on the account unless there is a financial agreement/payment plan on file in our office. Accounts on payment plans will not be assessed interest for the first 180 days as long as the terms of the payment plan are in good standing.
- Full pay cash discount: We offer to all clients without insurance a 5% paperwork reduction courtesy for all services paid day of service with cash or credit card.

When a payment plan is entered into between the dental office and a client a signed financial agreement/payment plan must be on file in the patient's chart. The financial plan will outline the terms of the agreement noting the amount to be paid in a specified time period. If a payment is missed at that time the balance will be due in full. All account balances over 90 days will be charged interest unless there is a financial plan in place at which time interest will not be assessed, if the terms of the payment plan are upheld, if the balance is paid off within 180 days.

Clients with delinquent accounts will not be provided additional appointments until their account is in good standing.

Broken or Missed Appointments: **To reschedule or cancel an appointment, you must notify us at least 24 hours in advance to avoid a missed appointment fee of up to $100.00. (fee based on appointment length and /or number of appointments missed). Missed or broken appointments prevent others from receiving the dental care they deserve.**

1) We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

I have read and understand this document in it's entirety; outlining the office and financial policies of Shawn R. McDevitt, DDS and agree to these terms.

Signature of patient or parent/guardian: _____ date_____

STATEMENT OF PRIVACY PRACTICES

Shawn R. McDevitt, DDS
307 S. 11th Avenue
Yakima, WA 98902
509-453-5568

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We may use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the State of Washington. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone-even family members-without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current and future patients; so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMATION

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines and postcards.

PATIENT RIGHTS

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other that state above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at Shawn R. McDevitt, DDS. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Shawn R. McDevitt, DDS

Shawn R. McDevitt, DDS
307 South 11th Avenue
Yakima, WA 98902
509-453-5568

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Shawn R. McDevitt, DDS. The statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The statement of Privacy Practices is also posted in the facility.

Shawn R. McDevitt, DDS reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Any member of my immediate family (Includes Spouse)	_____YES	_____NO
Spouse Only	_____YES	_____NO
Other (*Please Specify*):	_____YES	_____NO

_____ _____
Name of Patient or Personal Representative **Signature of Patient** or Personal Representative

_____ _____
Date Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

RECORD OF ACKNOWLEDGEMENT NOT OBTAINED

Provided prior to treatment? _____YES _____NO

Date provided? _____YES _____NO

Reason for denial:

_____Needed more time to review Statement of Privacy Practices.

_____Wanted to consult with another person before signing.

_____Reason not given.

_____Other (Explain):_____

_____