MC Dental Care, PLLC
Home of the WOW!

Patient Health History/Record Update

Have there been any changes in your health? If so, please explain.

_____

Please list all prescription medications, over-the-counter medications, or herbal supplements that you are currently taking.

_____

_____

Have you been hospitalized or had a major surgery in the past year? If so, please explain.

_____

Do you have any new allergies to medications, metals, latex, etc.? If so, please list them.

_____

Are you currently under a doctor's care? If so, what are you being treated for?

_____

Please list the name and phone number of your current physician.

_____

Please provide us with an emergency contact name and phone number.

_____

Please provide us with any information that may have changed within the past year:

Address _____

Phone # _____

Employer _____

Dental Insurance _____

Please provide us with your current e-mail address.

_____

Please choose your method of confirmation:

TELEPHONE CALL OR E-MAIL _____

HOME _____

CELL _____ **TEXT** **YES**_____ **NO**_____

WORK _____

Patient Name (please print) _____

Patient/Representative Signature _____

Today's Date _____ **Team Member** _____

Assignment of Insurance Benefits, Payment Policy, and Payment Options

The policy of MCDental Care, PLLC is to be paid directly by your insurance company. By signing the Consent for Services, you authorize direct payment to MCDental Care, PLLC and assume responsibility of all non-covered services or provider charges that may exceed insurance payment.

_____Our payment policy is as follows:
Initial

- **Payment is required the day services are rendered.**
- **Returned checks are subject to a $36 NSF fee and may be subject to an additional collection fee.**
- **Balances over 30 days may be subject to additional collection action.**
- **All accounts not paid within 90 days will be sent to a collection agency.**

For your convenience, we offer several payment options. Please read the following information:

- **Cash or Check.**
- **Visa, MasterCard, or American Express.**
- **Interest-free or extended financing through CareCredit.**

Credit balances on your MCDental Care, PLLC account are subject to reimbursement. A check will be issued by MCDental Care, PLLC within thirty days of your request for a refund. However, processing/transaction fees will be deducted from any refund in which credit balances occur due to a personal overpayment by credit card or CareCredit.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. This dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½% per month (18% annum) on any unpaid balance will be charged to the patient on all accounts exceeding 30 days past due, unless written financial arrangements are satisfied.

_____MCDental Care, PLLC can only estimate insurance payments and laboratory costs. All dental services not paid by
Initial insurance are charged directly to the patient. Any unpaid balance, as well as attorney fees, court costs, and collection costs incurred by collection and enforcement of a debt are the responsibility of the patient.

Cancellation Policy

_____MCDental Care, PLLC updated cancellation policy: After hours, please contact Dr. Dziurgot on her cell (586.823.0422) to reschedule. There will be a $35 fee for any cancellation within 2 business days.
Initial If two appointments are cancelled or no showed within 2 business days notice within a 12 month period, MCDental Care, PLLC will place your name on a call list. Three appointments without 2 business days notice within a 12 month period will result in permanent dismissal from the practice.

Patient Acknowledgement and Consent for Services

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 the doctors at the next appointment without fail.

I have had full opportunity to read and consider the contents of this form and your Notice of Privacy practices. I understand that by signing below, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form.
I have read the above conditions of treatment and payment and agree to their content.

_____ Date:_____
Signature of patient, parent or guardian

_____ Date:_____
Signature of dentist/hygienist