



McLemore Dentistry, LLC
Restorative, Cosmetic, & Implant Dentistry

5740 Carmichael Road, Montgomery, AL 36117
Phone (334) 277-9570 Fax (334) 277-0152

Email: scheduling@mclemoredmd.com Website: drmclemoredentistry.com

Please return this completed form along with a copy of both sides of your dental insurance cards and driver's license (at least 5 days before your appointment) so that we may be prepared for your visit. You may fax (334-277-0152) during normal business hours of 7:00am-3:00pm M-Th, email (scheduling@mclemoredmd.com), or return by mail.

Patient Information

Date: ____/____/____

Patient Name: _____ (_____)
Last Name , First Middle Preferred Name

Male female Family Status: single married widowed divorced separated child

Social Security # ____-____-____ Birth Date ____/____/____ Age ____ Driver License # _____

Phone (Home): (____)-____-____ (Work): (____)____-____ Ext: _____ Best Time to Call: _____ am pm

Cell Phone: (____)-____-____ Fax: (____)-____-____ Email: _____@_____

Are you using Social Media? [] Facebook [] Twitter [] Instagram [] Other _____

Home Street Address: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

Person to contact in case of an emergency: Name: _____

Phone: () _____ Relationship to you: _____

Name of the Person you give us permission to discuss your dental treatment:

First. Last. Relationship to you

Whom may we thank for referring you to our practice? Name: _____

Another Patient Friend Relative Dental Office TV Yellow Pages Internet Other

Please explain: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse parent or legal guardian the person responsible for payment

Last Name: _____ First Name: _____ Middle: _____

Male Female Married Single Divorced Widowed

Social Security # ____-____-____ Birth Date: ____/____/____

Phone Home: (____)-____-____ Work: (____)-____-____ Ext.: _____ Best Time to Call: _____

Employment Information

Employer Name: _____ Occupation: _____

How long employed: _____ [] Months/ [] Years Work hours: _____ Phone _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Dental Insurance Information

Primary Dental Insurance

Dental Insurance Company / Plan : _____

Effective Date: ____/____/____ Name of Insured: (as on your insurance card): _____

Is the Insured a patient in our office? Yes No Insured's Birth Date: ____/____/____ ID #: _____

Group #: _____ SS#: ____-____-____

Insured's Employer: _____ City _____ State: _____

Patient's relationship to insured: Self Spouse Child Other: _____

Secondary Dental Insurance (Note; Many Secondary Dental Plans do not pay the same as if they are Primary)

Secondary Dental Insurance Company/ Plan _____

Effective Date: ____/____/____ Name of Insured: (as on your insurance card): _____

Is the Insured a patient in our office? Yes No Insured's Birth Date: ____/____/____ ID #: _____

Group #: _____ SS#: ____-____-____

Insured's Employer: _____ City _____ State: _____

Patient's relationship to insured: Self Spouse Child Other: _____

Please remember to attach a copy of the front and back of your dental insurance cards and your Driver's License so that we may verify your coverage and benefits 5 days before your first appointment with our office.

Health Information

List Daily Rx Medications / Prescriptions

Medication or Prescription	Reason for the Medication or Prescription
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.
11.	11.
12.	12.

MEDICAL HISTORY

Have you ever had any of the following? Please check those that apply:

- | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> AIDS/HIV
<input type="checkbox"/> Allergies
<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Acid Reflux Disease
<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Artificial Joints
<input type="checkbox"/> Asthma
<input type="checkbox"/> Blood Disease
<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Cancer
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Diet controlled
<input type="checkbox"/> Medication Rx
<input type="checkbox"/> Take Insulin
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Drug Addictions
<input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding
<input type="checkbox"/> Fear of Dentists
<input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> Fosamax, Boniva, Reclast, Aredia, Zometa, etc _____
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Growths, Tumors,
<input type="checkbox"/> Head/Face Injuries
<input type="checkbox"/> Heart Disease/Attack
<input type="checkbox"/> Heart Valve Problem
<input type="checkbox"/> Hepatitis A, B, C
<input type="checkbox"/> Hospitalizations
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Jaundice
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Major Surgery | <input type="checkbox"/> Mental Disorders
<input type="checkbox"/> Methyltrexate Rx
<input type="checkbox"/> Mouth Injuries
<input type="checkbox"/> Nervous Disorders
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Psychiatric Problems
<input type="checkbox"/> Pregnant Now

Due date: _____
<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Smoker
<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Recent Steroid Rx's
<input type="checkbox"/> Stroke
<input type="checkbox"/> TMJ jaw problems | <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Take Aspirin Daily
<input type="checkbox"/> Take Blood Thinners
<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Codeine Allergy
<input type="checkbox"/> Penicillin Allergy
<input type="checkbox"/> Anesthetic Allergy
<input type="checkbox"/> Snoring/Sleep Apnea
Allergies Please List Below:

_____ |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
 If yes, please explain: _____

• Are you now under the care of a physician? Yes No
 If yes, please explain: _____

• Do you have any health problems that need further clarification? Yes No
 If yes, please explain:



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Patient Appointment & Financial Policy

We want to provide you with the best care possible and will always do our best to help you understand your financial investment and maximize your insurance benefits. There may be services that are necessary for the treatment of your condition and maintenance of good health that are not covered by your dental insurance. Some services may be recommended for cosmetic or more personalized results which also may not be covered. After your initial examination, we will provide you with an individually tailored treatment plan and an estimate of your investment. Our Financial Coordinator will meet with you to explain your options, help you understand your insurance benefits, discuss available financing options and answer any questions you may have.

- Payment is due at the time of service. We accept cash, personal checks, and most major credit cards. We also offer several financing options to help you with your financial needs.
- All emergency dental services or any dental services performed without previous financial arrangements, must be paid at the time services are rendered.
- If you have insurance, we will submit claims on your behalf. Please understand, we cannot guarantee that your insurance will pay exactly as estimated. Coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility.
- You are responsible for all charges regardless of your insurance coverage.
- Deductible, co-payment, co-insurance and any non-covered service is due at the time of service.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form authorizes your insurance company to make payment directly to our office. By signing, you also authorize the release of any information concerning your treatment for the purpose of evaluating and administering claims for insurance benefits.
- The filing of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared by your carrier in 45 days, the unpaid portion will automatically become your responsibility and a statement will be issued to you for the unpaid portion. You are responsible for any amounts your insurance company chooses not to pay, for whatever reason.
- If for any reason my account becomes delinquent, I agree to pay all late charges, interest, collection fees, court costs and reasonable attorney/legal fees.
- Time, trained personnel, and dental equipment are reserved for each procedure. In order to provide the best services to our patients, we require at least a 24-hour notice for cancelling or for rescheduling your appointments. **A fee will be charged for any appointment cancelled or rescheduled without a 24-hour notice (\$50 for hygiene appointments and \$125/hr for doctor appointments).**

I have read, understand and accept the financial and dental insurance policies listed above and have had any and all questions answered to my satisfaction. I agree to pay for all treatment as described. I hereby authorize my insurance benefits to be paid directly to McLemore Dentistry, LLC. I understand that most financial payment plans require a routine credit assessment and do hereby give my permission in order to help make my dentistry more affordable. I understand that I am financially responsible for any and all charges and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I hereby authorize the release of pertinent medical/dental information necessary to process claims, to the insurance company as required. This contract shall be governed by the laws of the State of Alabama. Venue shall be proper in Montgomery County, Montgomery, Alabama.

Signature of Patient, Parent, Guardian, or Responsible Party

Date



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Consent for Services

I understand that dentistry is not an exact science and no guarantees or assurance of the outcome or results of treatment or surgery can be made or implied. I understand that excessive smoking, alcohol, sugar, poor oral hygiene and not following my doctor's home care instructions may affect my healing and may limit the success of my dental treatment.

I request and authorize Dr. McLemore and/or staff to provide dental services and fully understand that during, and following the procedure, surgery, or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I agree to the type of anesthesia and/or sedation Dr. McLemore chooses, and agree not to operate a motor vehicle or hazardous device for at least 12 hours or more until fully recovered from the effects of sedation or the anesthesia or drugs given for my care.

I give my permission for any photographs, images, x-rays, or models to be taken and used by McLemore Dentistry, LLC for the advancement of dentistry or staff training purposes.

I agree that you may contact me by calling, sending text messages or email.

I hereby authorize any release of any information, including the diagnosis and records of treatment to my insurance company, or other doctor's offices as requested.

After an initial examination, a written estimate for the recommended dental treatment will be given, and financial arrangements along with risks, benefits and alternative treatments will be discussed at that time.

I have read, understand, and agree to the above conditions of treatment.

Signature of Patient, Parent, Guardian, or Responsible Party

Date

MCLEMORE DENTISTRY, LLC MEDIA CONSENT FORM

5740 Carmichael Rd
Montgomery, Alabama 36117
334-277-9570

McLemore Dentistry, LLC is requesting your permission to use your likeness, image and/or personal testimony, or if you are a legal representative the likeness, image or testimony of the named person below, on its website, social media pages, or marketing material.

By signing below you are consenting to the use of your likeness, image and/or testimony, including but not limited to representations or depictions of the treatment provided to you and the effect thereof, by McLemore Dentistry, LLC for any lawful use McLemore Dentistry, LLC deems appropriate, including for treatment, advertising (including social media and electronic media), illustration and publication to the public at large for educational purposes. You also understand you are entitled to no consideration, remuneration or payment for the use of your images and/or testimony in any advertising, promotional or educational materials.

You understand that McLemore Dentistry, LLC will make all reasonable efforts to safeguard your privacy as required by law including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You also understand that McLemore Dentistry, LLC may not and has not conditioned the rendition of treatment to you upon your authorization of the use of your image and/or likeness or testimony.

You have read the foregoing in its entirety and understand its terms.

Patient Name

Patient/Authorized Representative Signature

Date

