JOHN McALLISTER, D.D.S.

1235 4th St Dr NW Hickory, NC 28601 www.mcallisterdentistry.com Phone (828) 322-6731 Fax (828) 267-2525

Welcome to McAllister Dentistry! We are pleased that you chose us to serve your dental needs. Our goal is to help you feel and look your best through excellent dental care. We appreciate the trust you have placed in us to evaluate your teeth and oral structures and we promise to be thorough and to plan together what you want and need. Our practice is for patients who place a high value on their teeth, health, self-esteem and well-being.

Dr. McAllister provides a full range of dental services for the entire family. We offer general and cosmetic dental care, implants, bridges, crowns, sleep apnea appliances and much more. We are serious about providing a caring environment, providing superior dental care and a proud of our dedication to our patients. For a more in-depth look at our office, please visit our website at www. mcallisterdentistry.com.

We see scheduled patients in our office Monday through Thursday from 8:30 am to 5 pm. If you are ever unable to attend a scheduled appointment, please notify us at least 48 hours in advance and we will reschedule your appointment.

In the unfortunate event that you need emergency dental care, we make every effort to get you in the office as soon as possible. If problems occur when the office is closed, our answering machine will give you an emergency phone number.

We are in-network with Delta Dental, Blue Cross Blue Shield and Cigna insurance companies. As a courtesy, we will file claims with all other dental insurance companies. Patients are ultimately responsible for any fees not covered by their insurance companies.

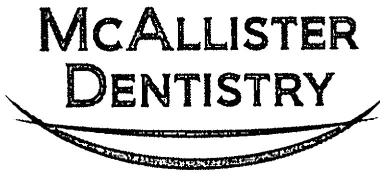
Please fill out the attached paperwork prior to your appointment and bring it with you to your first appointment. Also, be sure to bring photo identification and your dental insurance card.

We are always accepting new patients and appreciate the trust you show when you refer someone to our practice.

Your scheduled appointment is: ____

If you have any questions, please call us at (828)322-6731 or email us at: smile@mcallisterdentistry.com

We look forward to seeing you!



Dr. John McAllister enjoys dentistry and is pleased to provide his patients with the most comfortable and advanced dental treatments possible.

After attending UNC-Chapel Hill as an undergraduate, Dr. McAllister obtained his Masters of Physical Therapy from The Medical College of Virginia. He spent eight years as a Physical Therapist and the Director of Rehabilitation Services at Caldwell Memorial Hospital in Lenoir, NC. Dr. McAllister then returned to UNC-Chapel Hill to attended dental school where he graduated with honors and distinction. Dr. McAllister returned to his hometown of Hickory, NC to serve the dental needs of his community.

Dr. McAllister is a talented and accomplished dentist. He regularly attends continuing education courses fulfilling many times the required educational standards each year to bring his patients the best dentistry has to offer. He is a Mentor in the Dawson Academy and continues advanced studies and training with the Kois Research Center. Both the Dawson and Kois institutes are organizations that provide advanced level training to only the most motivated, curious, talented and dedicated dentists.

Dr. McAllister is also involved in numerous dental study clubs and dental organizations. He is a member of several national professional associations including the American Academy of Cosmetic Dentistry, American Academy of Implant Dentistry, Academy of General Dentistry, American Dental Association and is a Fellow in the International College of Oral Implantologists. As a member of the American Academy of Dental Sleep Medicine, Dr. McAllister has the training and experience needed to provide oral appliances to treat Obstructive Sleep Apnea for patients who choose to not use CPAP therapy.

Locally, Dr. McAllister has served as a board member of the Greater Hickory Cooperative Christian Ministry (CCM) and regularly volunteers in their dental clinic. In the past, he has served on the Advisory Board of Catawba Valley Community College Dental Hygiene program and the Hickory High School Athletic Boosters. Since education is of utmost importance to Dr. McAllister, he invites Dental Assisting students from Western Piedmont Community College to complete their student clinical rotations in his office. He strongly supports Lenoir-Rhyne University and is the "team dentist" as he is the On-Call dentist for student-athletes who have dental emergencies. Dr. McAllister and his staff are committed to giving back to the community and support many charitable organizations through volunteering time and services. Please visit our website at www.mcallisterdentistry.com to learn more about this practice and the organizations with which Dr. McAllister is involved.

Dr. McAllister enjoys being an active member of the community. He was solely responsible in the design and construction of the disc golf course at the Glenn C. Hilton, Jr. Memorial Park in Hickory and founded the UFO Club (Unifour Flying Objects Club). You can regularly see Dr. McAllister riding his bicycle around town, especially in the hilly neighborhoods. He attends First Presbyterian Church in Hickory, enjoys reading, domestic and international travel and snow skiing. Dr. McAllister and his wife, Carolyn, have two sons, Alex and Michael.

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Patient Information

Patient Name: ______________________ Date of Birth ______________

Address: ____

City: __________________ State: ________ Zip: ________

Telephone: (Home) ____________(Mobile)__________(Other)________

Email : ____

Social Security #: _________________

Circle one: Single Married Child Other // Sex: Male Female

Employer: ____

In case of Emergency Contact:

Name: ______________Relationship: _______ Phone Number:__________

Dental Insurance

Primary Insurance: ________________Subscriber Name ______________

Date of Birth: _______________Relationship to patient: ______________

ID #: ______________ Group #: __________ Insurance Tel #__________

Secondary Insurance: ______________Subscribers Name:________________

DOB: __________________ Relation to Patient: ______________

ID number: __________Group number: _______ Insurance Tel #_____________

DENTAL HISTORY

Name ______________________ Nickname ______________________ Age __________
Referred by ______________________ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist ______________________ How long have you been a patient? __________ Months/Years
Date of most recent dental exam ____ /____ /____ Date of most recent x-rays ____ /____ /____
Date of most recent treatment (other than a cleaning) ____ /____ /____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ______________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] ______ ☐ ☐
2. Have you had an unfavorable dental experience? ______ ☐ ☐
3. Have you ever had complications from past dental treatment? ______ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ______ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? ______ ☐ ☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? ______ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? ______ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ______ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? ______ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? ______ ☐ ☐
11. Have you ever experienced gum recession? ______ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ______ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? ______ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? ______ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ______ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ______ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? ______ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? ______ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ______ ☐ ☐
20. Do you frequently get food caught between any teeth? ______ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ______ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? ______ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ______ ☐ ☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? ______ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? ______ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? ______ ☐ ☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? ______ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? ______ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ______ ☐ ☐
30. Do you clench or grind your teeth together in the daytime or make them sore? ______ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? ______ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? ______ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? ______ ☐ ☐
34. Have you ever whitened (bleached) your teeth? ______ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? ______ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? ______ ☐ ☐

Patient's Signature ______________________ Date __________
Doctor's Signature ______________________ Date __________

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MEDICAL HISTORY

Patient Name ______________________ Nickname ______________ Age ________

Name of Physician/and their specialty ______________________

Most recent physical examination ______________________ Purpose ______________________

What is your estimate of your general health? ▢ Excellent ▢ Good ▢ Fair ▢ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

	YES	NO
1. hospitalization for illness or injury ________	▢	▢
2. an allergic or bad reaction to any of the following:	▢	▢
▢ aspirin, ibuprofen, acetaminophen, codeine		
▢ penicillin		
▢ erythromycin		
▢ tetracycline		
▢ sulfa		
▢ local anesthetic		
▢ fluoride		
▢ metals (nickel, gold, silver, ________)		
▢ latex		
▢ nuts ________		
▢ fruit ________		
▢ other ________		
3. heart problems, or cardiac stent within the last six months ________	▢	▢
4. history of infective endocarditis ________	▢	▢
5. artificial heart valve, repaired heart defect (PFO) ________	▢	▢
6. pacemaker or implantable defibrillator ________	▢	▢
7. orthopedic implant (joint replacement) ________	▢	▢
8. rheumatic or scarlet fever ________	▢	▢
9. high or low blood pressure ________	▢	▢
10. a stroke (taking blood thinners) ________	▢	▢
11. anemia or other blood disorder ________	▢	▢
12. prolonged bleeding due to a slight cut (INR > 3.5) ________	▢	▢
13. pneumonia, emphysema, shortness of breath, sarcoidosis ________	▢	▢
14. tuberculosis, measles, chicken pox ________	▢	▢
15. asthma ________	▢	▢
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) ________	▢	▢
17. kidney disease ________	▢	▢
18. liver disease ________	▢	▢
19. jaundice ________	▢	▢
20. thyroid, parathyroid disease, or calcium deficiency ________	▢	▢
21. hormone deficiency ________	▢	▢
22. high cholesterol or taking statin drugs ________	▢	▢
23. diabetes (HbA1c = ________) ________	▢	▢
24. stomach or duodenal ulcer ________	▢	▢
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) ________	▢	▢
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ________	▢	▢
27. arthritis ________	▢	▢
28. autoimmune disease ________ (i.e. rheumatoid arthritis, lupus, scleroderma)	▢	▢
29. glaucoma ________	▢	▢
30. contact lenses ________	▢	▢
31. head or neck injuries ________	▢	▢
32. epilepsy, convulsions (seizures) ________	▢	▢
33. neurologic disorders (ADD/ADHD, prion disease) ________	▢	▢
34. viral infections and cold sores ________	▢	▢
35. any lumps or swelling in the mouth ________	▢	▢
36. hives, skin rash, hay fever ________	▢	▢
37. STI/STD/HPV ________	▢	▢
38. hepatitis (type ____) ________	▢	▢
39. HIV/AIDS ________	▢	▢
40. tumor, abnormal growth ________	▢	▢
41. radiation therapy ________	▢	▢
42. chemotherapy, immunosuppressive medication ________	▢	▢
43. emotional difficulties ________	▢	▢
44. psychiatric treatment ________	▢	▢
45. antidepressant medication ________	▢	▢
46. alcohol/recreational drug use ________	▢	▢

ARE YOU:

	YES	NO
47. presently being treated for any other illness ________	▢	▢
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) ________	▢	▢
49. taking medication for weight management ________	▢	▢
50. taking dietary supplements ________	▢	▢
51. often exhausted or fatigued ________	▢	▢
52. experiencing frequent headaches ________	▢	▢
53. a smoker, smoked previously or use smokeless tobacco ________	▢	▢
54. considered a touchy/sensitive person ________	▢	▢
55. often unhappy or depressed ________	▢	▢
56. taking birth control pills ________	▢	▢
57. currently pregnant ________	▢	▢
58. diagnosed with a prostate disorder ________	▢	▢

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________ Date ________

Doctor's Signature ______________________ Date ________

ASA ______ (1-6)

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SLEEP SCREENING QUESTIONNAIRE

Sleep Well Carolina

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations?

Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze **1 = Slight chance of dozing**

2 = Moderate chance of dozing **3 = High chance of dozing**

SITUATION

Sitting and reading ______
Watching television ______
Sitting inactive in a public place (i.e. theater) ______
As a car passenger for an hour without a break ______
Lying down to rest in the afternoon ______
Sitting and talking to someone ______
Sitting quietly after lunch without alcohol ______
In a car, while stopping for a few minutes in traffic ______

TOTAL SCORE ______

A score of 8 or greater indicates the possibility of sleep disordered breathing.

THORNTON SNORING SCALE

Snoring has a significant effect on the quality of life for many people. Snoring can affect the person snoring and those around him/her, both physically and emotionally. Use the following scale to choose the most appropriate number for each situation. (Go to the 4th statement if you have no bed partner.)

0 = Never **1 = Infrequently (1 night per week)**

2 = Frequently (2-3 nights per week) **3 = Most of the time (4 or more nights per week)**

My snoring affects my relationship with my partner ______
My snoring requires us to sleep in separate rooms ______
My snoring is loud ______
My snoring affects people when I am sleeping away from home (i.e. hotel, camping, etc.) ______

TOTAL SCORE ______

A score of 5 or greater indicates your snoring may be significantly affecting your quality of life.

PATIENT NAME ____________________________ **DATE:** __________

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McAllister Dentistry

Financial Agreement

We are committed to providing you with the highest quality of care and our fees are a reflection of that quality.

We provide a variety of payment options from cash, checks, credit cards (Visa, MasterCard & Discover) and Care Credit.

We will communicate all recommended treatment options and costs prior to the start of treatment.

Payment is expected at the time of treatment.

A guardian who accompanies a child to our office is responsible for payment for all services rendered.

Dental Insurance

Even if you do not currently have dental insurance, you might have coverage in the future. Please read the following statements to understand our insurance policies.

As a courtesy to our patients with dental insurance benefits, we will submit dental claims to assist in receiving dental insurance reimbursement. We require that any applicable deductibles and estimated patient co-pays be paid at the time treatment is rendered.

We are in-network with Delta Dental, Cigna Dental and Blue Cross Blue Shield.

We can not guarantee payment from an insurance company and any remaining balance left after insurance payment is the patient's responsibility.

We will do our best to help you understand your dental insurance coverage but it is ultimately your responsibility to understand the type of dental insurance you have and the benefits selected by you and/or your employer. You (not the insurance company) are responsible for the fee of services rendered.

I understand and agree with the above policies:

Signature:____ Date: ____________________

McAllister Dentistry

Cancellation & Dismissal Policy

Cancellations: Please understand that our appointment times are scheduled in advance to allow us to properly staff the office and to care for each patient's needs during scheduled visits. Since appointment times are in high demand, we appreciate advance notice from our patients who are unable to keep their scheduled appointments.

Dr. McAllister reserves the right to dismiss an established patient from our practice when 3 appointments are missed without the patient providing us with 2 business days notice of cancellation. If a new patient misses 2 confirmed appointments, that new patient will not be rescheduled.

Dismissal: Patients who do not complete needed treatment and/or refuse to signed a Treatment Refusal Form will be dismissed from this practice. Dr. McAllister will not be held responsible for dental problems that continue to worsen due to patient neglect.

We provide a professional and friendly environment and treat our patients with dignity and respect. We expect the same attitude and behavior from our patients otherwise they will be dismissed from this practice.

Patients with delinquent accounts will be dismissed and their accounts turned over to a collections agency.

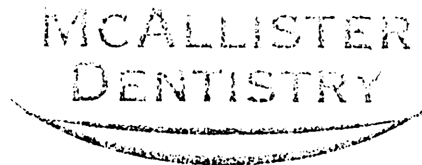
NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly & indirectly. • Obtain payment from third-party payers, i.e. my dental and/or medical insurance companies, my family head of household, guardian or primary insurance account holder, or collections agencies. • Conduct normal healthcare operations such as quality assessments and physician certifications.

I may request to read the complete copy of your Notice of Privacy Practices which contains more complete descriptions of HIPAA. I understand that this organization has the right to change it Notice of Privacy practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: ____ Date: ________________



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Dental Record Release Form

To: ______________________________________

Address: ______________________________________

____

I authorize the release of dental records and medical records relevant to dental treatment, or copies of such, and request that they be transferred to:

John S. McAllister, D.D.S., P.A
1235 4th Street Drive, NW
Hickory, NC 28601
Telephone: (828) 322-6731
Fax: (828) 267-2525
Email: smile@mcallisterdentistry.com

Print Name: ______________________________

Signature: ______________________________

Date: ______________________________

McAllister Dentistry is located in **Viewmont,** in **Northwest Hickory**

1235 4th St. Dr. NW, Hickory, NC 28601
(828) 322-6731

Travelling I-40 West (from Statesville)
-Take exit 125, turn Right on to Lenoir-Rhyne Blvd
-Turn Left at 4th stoplight on to 1st Ave SE
-Next light turn Right on 127 N
-At stoplight, turn Left on 13th Ave NW (Chic-fil-A & Wendy's are on the corner)
-At stop sign you will see McAllister Dentistry in front of you.
-Turn Right on 4th St. Dr. NW and immediately turn Left on 13th Ave to park behind the building

Travelling I-40 East (from Valdese, Morganton)
-Take Exit 125, turn Left on to Lenoir-Rhyne Blvd
-Turn Left at 5th stoplight on to 1st Ave SE
-Next light turn Right on 127 N
-at stoplight turn Left on 13th Ave. NW (Chic-fil-A & Wendy's are on the corner)
-At stop sign you will see McAllister Dentistry in front of you.
-Turn Right on 4th St. Dr. NW and immediately turn Left on 13th Ave to park behind the building

Travelling 321 South (from Granite Falls, Lenoir)
-Cross over 321/Catawba River bridge
-At 2nd stoplight after bridge, turn Left between Raceway and CVS Pharmacy
-Go straight through next stoplight to cross over Old Lenoir Rd
-Turn Left at next stoplight on to 12th Ave NW (also called Geitner Rd.)
-Travel about one mile to next stoplight
-Turn Right on 6th St. NW
-Take 2nd Left on 9th Ave. NW (road changes name to 8th Ave Dr.)
-At light, turn Left on 4th St. Dr. NW
-McAllister Dentistry is on Left on corner of 4th St. Dr. and 13th Ave NW
-Turn Left on 13th Ave NW to park behind building

Travelling 321 North (from Lincolnton)
-Take Hwy 127 N exit
-Turn Right at top of exit ramp to travel North on Hwy 127
-Turn Left on 13th Ave NW (Chic-fil-A & Wendy's are on the corner)
-at stop sign you will see McAllister Dentistry in front of you
-Turn Right on 4th St. Dr. NW then immediately turn Left on 13th Ave to park behind the building