Marcus Dental Care

Date: _____ Referral Source: _____

Patient Information

First Name: _____ Last Name: _____ Preferred: _____

SS#: _____ Birth Date: _____ Sex: Male / Female Title: Mr. Mrs. Ms. Dr.

Home Address: _____

(Street) (City, State) (Zip)

Patient's Home #: _____ Patient's Work #: _____

Patient's Cell #: _____ Email Address: _____

Employer: _____ Policy Holder _____

Insurance Company_____ Policy Holder SS#/DOB_____

Emergency Contact Name: _____ Relationship to you: _____

Emergency Contact Phone#: _____

Dental History

Reason for today's visit: _____

Former Dentist: _____ Date of last dental care: _____

Do you brush daily? **Yes/ No** Do you floss daily? **Yes/ No**

Please circle if you have experienced ANY of the following (please mark ALL responses)

Bad Breath	**Yes/ No**	Heat Sensitivity	**Yes/ No**	Bleeding Gums	**Yes/ No**
Biting Sensitivity	**Yes/ No**	Loose Teeth	**Yes/ No**	Jaw Joint Pain	**Yes/ No**
Broken Fillings	**Yes/ No**	Orthodontic Work	**Yes/ No**	Cold Sensitivity	**Yes/ No**
Periodontal Treatment	**Yes/ No**	Food Collection	**Yes/ No**	Sores in Mouth	**Yes/ No**
Grinding Teeth	**Yes/ No**	Sweet Sensitivity	**Yes/ No**		

Print Patient Name: _____

Patient Signature: _____ **Date:** _____

Medical History

Physician's Name: _____

Phone #: _____ Date of Last Physician Visit: _____

Please circle if you have experienced ANY of the following (please mark ALL responses)

Abnormal Bleeding	Yes/ No	Headaches	Yes/ No	Radiation	Yes/ No
AIDS (HIV+)	Yes/ No	High Blood Pressure	Yes/ No	Chemotherapy	Yes/ No
Alcohol/Drug Abuse	Yes/ No	Heart Problems	Yes/ No	Shortness of breath	Yes/ No
Allergies	Yes/ No	Hepatitis/Liver Disease	Yes/ No	Stroke	Yes/ No
Anemia	Yes/ No	Herpes/Fever Blisters	Yes/ No	Thyroid Problems	Yes/ No
Artificial Heart Valves	Yes/ No	Handicaps/Disabilities	Yes/ No	Tobacco Habit	Yes/ No
Arthritis	Yes/ No	Diabetes	Yes/ No	Artificial Joints	Yes/ No
Take Aspirin	Yes/ No	Tuberculosis	Yes/ No	Cortisone/Steroid treatment	Yes/ No
Asthma	Yes/ No	Epilepsy	Yes/ No	Psychiatric Care	Yes/ No
Chest Pains	Yes/ No	Kidney/Bladder Disease	Yes/ No	Ulcers	Yes/ No
Back Problems	Yes/ No	Pace Maker	Yes/ No		
Blood Disease	Yes/ No	Currently Pregnant	Yes/ No		
Cancer	Yes/ No	Currently Nursing	Yes/ No		
Taking any medications	Yes/ No	On Birth Control Pills	Yes/ No		

Please List any medications you are taking:

_____

_____

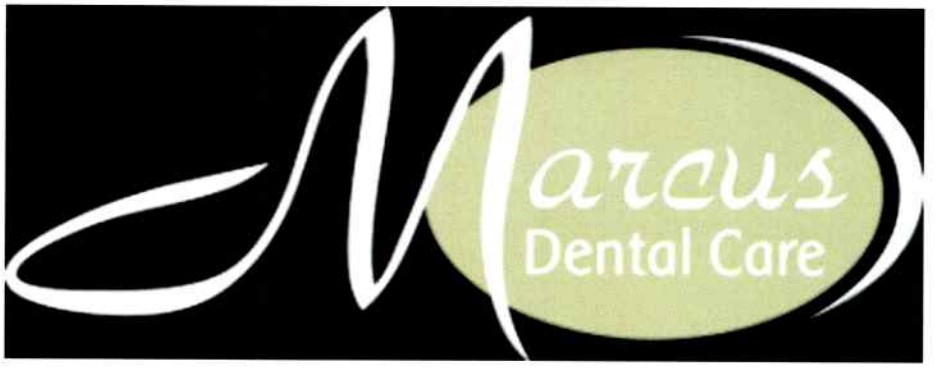
Are you **ALLERGIC** to any medication, anesthetic, or materials such as zippers, costume jewelry, latex gloves, etc.?

Yes/ No if yes, please explain: _____

Do you have any disease or condition or anything about your health that we have not covered and that we may need to know? **Yes/ No** if yes, please explain:

_____

_____



Name _____
Last First

Date _____

Please tell us how you learned about our practice. (Select **ALL** that apply)

_____	Referral - Patient	*Name:* _____
_____	Referral - Staff	*Name:* _____
_____	Referral - Dentist/Dr	*Name:* _____
_____	Our website	
_____	Internet search	(e.g. a basic search for "dentist")
_____	Insurance Company	*Which insurance?* _____
_____		
_____		

Marcus Dental Care

24hour Cancellations and/or Failing Scheduled Hygiene Appointments Policy

As you may already realize, our hygiene appointments are precious to many patients and the schedule stays very full. Therefore, due to patients failing to notify the office 24hrs in advance of cancellations and/or failing to show for already scheduled routine hygiene appointments, our office has implemented a $35.00 fee.*

*In the case of Root Planing/Perio Scaling appointments, there will be a $50.00 fee at the time of any cancellation/and or failing to show for the appointment.

If the reason for cancelling less than 24hrs or failing your scheduled appointment is a family emergency or any extenuating circumstances, we will happily eliminate the charges. This is our attempt to better accommodate our patients!

Thank you - Dr. Carlene Marcus & Staff

Signature: _____

Date: _____

Marcus Dental Care

Consent for Services and Financial Agreement

I, the undersigned, hereby authorize Marcus Dental Care to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by her to make a thorough diagnosis of my condition. I also authorize Marcus Dental Care to perform any and all forms of treatment, medication and therapy that may be indicated in connection with treatment, and further authorize and consent to the employment of such assistance as she deems fit. I also understand that the use of anesthetic agents embodies a certain risk.

Insurance

Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentages of the charge. Some have annual caps or multiples levels of coverage. I understand that the payment of my bill is my legal obligation. All filings of insurance papers and confirmation of insurance payments to be made by my insurance carrier are my responsibility, as is determining providers covered by my current insurance. Any assistance in this matter granted by the above doctor and/or staff is given strictly as a courtesy and implies no responsibility on their part for eligibility, filing, follow-through, or confirmation. Notification of change of insurance carrier or level of coverage (e.g.PPO) is my responsibility, as is any change of address.

Delinquent Accounts

IN THE EVENT THAT THIS ACCOUNT SHOULD BECOME DELINQUENT AND IS THEREFORE PLACED IN THE HANDS OF AN ATTORNEY FOR COLLECTION, I AGREE TO PAY ATTORNEY FEES OF 33 AND 1/3% OF THE UNPAID BALANCE OWING, PLUS ALL COURT COSTS, AND INTEREST. INTEREST IS CHARGED AT A RATE OF 1.5% PER MONTH (18% APR), BEGINNING 30 DAYS AFTER THE MONIES HAVE BECOME DUE OR EXPENSES HAVE BEEN INCURRED. I FURTHER AGREE TO PAY RETURNED CHECK CHARGES OF $50.00 PER RETURNED CHECK.

This agreement is reaffirmed each time services are received by me or any person on my account, including, but not limited to, any child, stepchild, or parent within my family, who receives services from the above-named provider or any other provider within the practice.

_____ _____

Signature Printed Name

_____

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____