Referral Source: _____

Patient Information

Name: _____
First Last (Preferred Name)

Title: Mr. Mrs. Ms. Dr. Status: Married/ Single/Child/Other: _____ Sex: Male / Female

SS#: _____ Birth Date: _____

Home Address: _____

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**		

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)

AIDS (HIV+)	**Yes/ No**	Chest Pains	**Yes/ No**	Jaundice	**Yes/No**
Allergies: _____	**Yes/ No**	Cortisone/Steroid treatment	**Yes/ No**	Kidney/Bladder Disease	**Yes/ No**
Alcohol/Drug Abuse	**Yes/ No**	Diabetes	**Yes/No**	Pace Maker	**Yes/ No**
Anemia	**Yes/ No**	Epilepsy	**Yes/ No**	Psychiatric Care	**Yes/ No**
Arthritis	**Yes/ No**	Excessive Bleeding	**Yes/No**	Pregnancy (**current**) Due date: _____	**Yes/No**
Artificial Heart Valves	**Yes/ No**	Handicaps/Disabilities	**Yes/ No**	Radiation	**Yes/ No**
Artificial Joints	**Yes/ No**	Headaches/TMJ	**Yes/ No**	Shingles	**Yes/No**
Asthma	**Yes/ No**	Heart Problems	**Yes/ No**	Sickle Cell Anemia	**Yes/No**
Back Problems	**Yes/ No**	Hepatitis/Liver Disease	**Yes/ No**	Stomach Problems	**Yes/ No**
Blood Disease	**Yes/ No**	Herpes/Fever Blisters	**Yes/ No**	Stroke	**Yes/ No**
Cancer	**Yes/ No**	**Type of cancer if yes:**_____		Thyroid Problems	**Yes/ No**
Chemotherapy	**Yes/ No**	High Blood Pressure	**Yes/ No**	Ulcers	**Yes/ No**
		Other: _____			

Please List any medications you are taking:

_____

_____

_____

Are you **ALLERGIC** to any medication, anesthetic, or materials such as zippers, costume jewelry, latex gloves, sulfa, 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:

_____

_____

_____

Missed Appointment Policy

As you may already realize, our appointments are precious to many patients and the schedule stays very full. Therefore, due to patients failing to notify the office 24 hours in advance of cancellations and/or failing to show for already scheduled 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 24 hours or failing to show for 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: _____

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 charges. Some have annual caps or multiples levels of coverage. I understand that the payment of my bill is my legal obligation. All confirmation of insurance eligibility 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 33.3% 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. ANY PROFESIONAL/COURTESY DISCOUNT IS CONTINGENT UPON EXECUTION OF THE PAYMENT TERMS OUTLINED ABOVE AND MAY BE REVERSED AT THE DISCRETION OF THE PRACTICE IF THE ACCOUNT GOES INTO DEFAULT.

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 receive services from the above-named provider or any other provider within the practice.

_____ _____

Signature **Printed Name**

_____

Date

Acknowledgment of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

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)

_____
_____

_____
_____