Dena Marcus D.D.S. Claire Tyler D.D.S.

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Date:_____

PATIENT INFORMATION

Patient Name: _____ [ ] Male [ ] Female [ ] Married [ ] Single [ ] Other_____

Social Security #:_____ Birth Date:_____ Driver's License #: _____ State_____

Home Address: _____ City _____, State____ Zip_____

Phone (Home) _____ (Work)_____ (Cell)_____ Email _____

Employer: _____ Occupation _____

Employer Address:_____ City & Zip Code _____

Spouse's Name: _____ Birth Date:_____ Social Security #_____

Children's Names & Ages:_____

Whom may we thank for referring you to our office?_____

Person to contact in case of emergency: _____ Phone:_____

Previous Dentist:_____Phone # _____

INSURANCE INFORMATION or Provide Your Insurance Card

Primary Insurance: Name of Insured _____ Relationship to patient: [ ]Self [ ]Spouse [ ]Child [ ]Other

Insured's birth date: _____SS#_____ Is insured a patient? [ ] Yes [ ] No

Insured's address: _____ City, State &Zip _____

Insured's employer: _____ Group # _____

Insurance Company: _____ Insurance Phone #_____

Insurance address: _____ City, State & Zip _____

Secondary Insurance: Name of Insured _____ Relationship to patient: [ ]Self [ ]Spouse [ ]Child [ ]Other

Insured's birth date: _____SS#_____ Is insured a patient? [ ] Yes [ ] No

Insured's address: _____ City, State &Zip _____

Insured's employer: _____ Group # _____

Insurance Company: _____ Insurance Phone #_____

Insurance address: _____ City, State & Zip _____

Office Use Only: Doctor's Comments

_____

_____

_____ Signature: _____ Date:_____

HEALTH & DENTAL INFORMATION

Name of medical doctor: _____Phone# _____Date of last Exam_____

Medical Insurance provider _____ Medical # _____

Are you under medical treatment now? []Yes [ ] no. If yes _____

Have you been admitted to a hospital or needed emergency care during the past two years? [ ] Yes [ ] No. If yes explain_____

Are you taking any medication (s) including non-prescription medicine and supplements [ ]Yes [ ] No.

If Yes, please list ALL medications you are taking :_____

_____

Are you allergic to or have you had any reactions to the following: Local Anesthetics [ ] Yes [ ]No

Penicillin or any other Antibiotics?_____ [ ]Yes [ ]No Sulfa Drugs [ ] Yes [ ] No

Any Metals (nickel) _____ [ ] Yes [ ]No Latex [ ] Yes [ ] No

Other (please list) _____

Women Only: Are you pregnant? [ ] Yes [ ] No Due Date:_____ Are you nursing? [ ] Yes [ ] No

Do you have or have you had any of the following? (please mark yes or no)

Yes	No		Yes	No		Yes	No		Yes	No	
[ ]	[ ]	Acid Reflux	[ ]	[ ]	Emphysema	[ ]	[ ]	Heart murmur	[ ]	[ ]	Radiation therapy
[ ]	[ ]	Aids/HIV	[ ]	[ ]	Epilepsy/convulsions	[ ]	[ ]	Hepatitis, Type _____	[ ]	[ ]	Recreational Drugs
[ ]	[ ]	Anemia	[ ]	[ ]	Excessive Bleeding	[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Respiratory problem
[ ]	[ ]	Angina	[ ]	[ ]	Fainting/Seizures	[ ]	[ ]	Jaundice	[ ]	[ ]	Rheumatic Fever
[ ]	[ ]	Arthritis	[ ]	[ ]	Glaucoma	[ ]	[ ]	Joint replacement/implant	[ ]	[ ]	S.T.D's
[ ]	[ ]	Asthma	[ ]	[ ]	Growths	[ ]	[ ]	Kidney disease	[ ]	[ ]	Smoke/use tobacco
[ ]	[ ]	Cancer	[ ]	[ ]	Hay Fever/allergies	[ ]	[ ]	Low Blood Pressure	[ ]	[ ]	Stroke
[ ]	[ ]	Chest Pains	[ ]	[ ]	Head Injuries_____	[ ]	[ ]	Mental or nervous disorder	[ ]	[ ]	Thyroid problem
[ ]	[ ]	Diabetes	[ ]	[ ]	Heart attack_____	[ ]	[ ]	Mitral valve prolapse	[ ]	[ ]	Tuberculosis
[ ]	[ ]	Dizziness	[ ]	[ ]	Heart disease	[ ]	[ ]	Pacemaker/shunt	[ ]	[ ]	other_____

Have you ever taken prescription diet drugs (Phen-Fen,Redux etc.) [ ] Yes [ ] No

Bisphosphonates (Fosamax, Boniva, ect.) [ ] Yes [ ] No

Have you ever had any complications following dental treatment? [ ] Yes [ ] No _____

Financial Agreement and Release

Financial arrangements must be made in advance. As a courtesy, we will be happy to assist you in the billing and collection from your insurance company. However you are responsible for all charges and we do not take any responsibility for services not paid by your insurance company. Your portion is due at the time services are rendered. Accounts not paid in full by the end of the first billing cycle will have a late charge of 1.8%. Returned checks are subject to a $25 fee.

Appointments cancelled without 24hr business day notice will be charged $50.

I authorize the release of any information including the diagnosis and the records of any treatment or exam rendered to me during the period of such dental care to third party payers and/or health practitioners.

X_____Date_____ Relation if other then patient_____

Signature of responsible party