

ABOUT YOU

Today's Date: _____ Email Address: _____
 Last Name: _____ First Name: _____
 I prefer to be called: _____ Marital Status: Single Married Divorced Widowed Separated
 Birthdate: _____ Age: _____ Soc. Sec. #: _____ Gender: Female Male
 Home Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____
 Driver's License #: _____ Whom may we thank for referring you? _____
 Best way to reach you during office hours? Home Work Cell Email Regular Mail
 Other family members seen by us: _____
 Employer: _____ How long there: _____ Occupation: _____
 Employer's address: _____
 City: _____ State: _____ Zip: _____
 In Case Of Emergency, Whom Should We Contact:
 His / Her Name: _____ Relation: _____
 Work Phone: _____ Cell Phone: _____ Home Phone: _____

SPOUSE INFORMATION

His / Her Name: _____ Birthdate: _____ Soc. Sec. #: _____
 Employer: _____
 Work Phone: _____ Ext: _____ Driver's License #: _____

INSURANCE INFORMATION

Primary Insurance:
 Dental Coverage? Y N Orthodontic Coverage? Y N Medical Coverage? Y N
 Insurance Co. Name: _____ Phone #: _____ Group: _____
 Insurance Co. Address: _____
 City: _____ State: _____ Zip: _____
 Insured's Name: _____ Insured's Soc. Sec. #: _____
 Insured's Birthdate: _____ Relation: _____ Insured's Employer: _____
 Employer's Address: _____
 City: _____ State: _____ Zip: _____
Secondary Insurance: (if applicable)
 Dental Coverage? Y N Orthodontic Coverage? Y N Medical Coverage? Y N
 Insurance Co. Name: _____ Phone #: _____ Group: _____
 Insurance Co. Address: _____
 City: _____ State: _____ Zip: _____
 Insured's Name: _____ Insured's Soc. Sec. #: _____
 Insured's Birthdate: _____ Relation: _____ Insured's Employer: _____
 Employer's Address: _____
 City: _____ State: _____ Zip: _____

The above information is true and correct to the best of my knowledge. I authorize and give consent to perform dental service agreed between the dentist(s) and myself and/or to be necessary or advisable, including the use of local anesthesia and other medications as indicated. I understand that, regardless of insurance coverage, I am responsible for payment of services rendered and that a finance charge of 23% APR or 1.92% per month will be applied to accounts past due 90 days or more.

Patient Signature: _____ Date: _____

DENTAL HISTORY

Why have you come to the dentist today? _____
 Are your teeth sensitive to heat, cold or anything else? _____
 Are you currently in pain? Y N How is your dental health? Good Fair Poor
 Do you require antibiotics before dental treatment? Y N
 Do you floss daily? Y N Brush daily? Y N
 Type of bristles on your toothbrush? Hard Medium Soft
 Do your gums bleed? Y N Do your gums itch? Y N
 Ever had periodontal disease? Y N Do you have mobility in your teeth? Y N
 Do you still have wisdom teeth? Y N Previous / Present Dentist? _____
 Last visit date? _____ Would you like fresher breath? Y N Whiter teeth? Y N
 Are you happy with your smile? Y N If not, what would you change? _____

MEDICAL HISTORY

Do you have a personal physician? Y N Your current health condition? Good Fair Poor
 Are you currently under the care of a physician? Y N Explain: _____
 Physician's name: _____
 Physician's address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Date of last visit? _____
 Do you smoke or use tobacco in any form? Y N
 Have you ever taken Phen-Fen, Redux or Pondimin? Y N
 Have you ever taken Bis-Phosphate medications (i.e. Aredia and Zometa)? Y N
 For Women: Are you taking birth control pills? Y N Are you pregnant? Y N Unsure
 Week #: _____ Are you nursing? Y N

Have you ever experienced any of the following?

- | | | | | |
|-------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Colitis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Headaches | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Attacks | <input type="checkbox"/> Lupus | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Steroid Therapy |
| <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Valves | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Ever Hospitalized | <input type="checkbox"/> Herpes | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> HIV+ / AIDS | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Seizures | |

Please list any serious medical condition(s) that you have experienced: _____
 Are you taking any perscription or over the counter drugs? Y N
 If yes, please list: _____

Are you allergic to any of the following?

Aspirin Barbiturates Codeine Dental Anesthetics Erythromycin Jewelry/Metals
Latex Penicillin Sedatives Sulfa Drugs Tetracycline Other: _____

I confirm that the medical history above states my past and present medical conditions.

Signature: _____ Date: _____

OUR FINANCIAL POLICIES

Welcome to Marcos & Marcos DDS. It is our pleasure to have you as our patient. Our commitment is to provide you with the best possible dental care and to keep you informed of treatment recommendations and financial obligations.

If you have dental insurance, we will be glad to help you receive your maximum allowed benefits.

The following is our office payment policy:

-  Payment is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, Discover and American Express.
-  If you are a patient with insurance, it is important to remember that your insurance plan is a contract between you, your employer and the insurance company. This contract is in no way a binding obligation between the dental insurance company and Marcos & Marcos DDS.
-  Our fees generally fall within the accepted range of the maximum allowance determined by each insurance carrier. This applies only to companies which pay a percentage of "usual, customary and reasonable" rates. This does not apply to companies which reimburse based on an arbitrary "schedule" of fees.
-  After your initial exam, you will receive a treatment plan which estimates your portion of payment. If we estimate and collect your co-payment and the insurance underpays or denies a benefit, you are responsible for the remaining balance.
-  While discouraged, a submitted insurance pre-estimate may be sent to your insurance company upon your request. The fee for this estimate is \$50.00.
-  Not all services are covered in all insurance contracts. Insurance companies arbitrarily select certain procedures they do not cover, based upon the premium/contract arranged by your employer.
-  In order for us to help you process your insurance claim for your reimbursement, please bring all insurance information with you. Also, please call your dental insurance carrier to expedite claims if a claim is not paid within 30 days, as the law requires.

Returned checks and outstanding balances over 90 days are subject to bank fees, collection fees and an interest rate charge of 23% APR or 1.92% per month. There is also a charge for broken appointments and those canceled without 2 business days notice. Please remember that the staff sets aside a designated amount of time for your particular type of treatment. If you miss an appointment without notifying our office, you will be required to pay 50% of the value of your next appointment (non-refundable) before scheduling. If you miss two scheduled appointments without notifying our office, you will be dismissed. We appreciate your understanding of how important keeping appointments is to the doctors and our other patients.

We hope by presenting our policies to you in the beginning, we will avoid any misunderstandings and have more time to dedicate to your dental care. If you have any questions regarding the above information or insurance coverage, please do not hesitate to ask. We are here to help you!

Patient Signature: _____ Date: _____