ANDREW MARSHALL, D.D.S.

Welcome to our Practice!

Today's Date _____

Name of Patient _____ Preferred Name _____ Sex: M_____F_____

Birthdate _____Age _____ SSN _____Marital Status _____

Mailing Address _____City_____State_____Zip_____

Home Phone _____Cell _____E-mail address _____

Please circle the ways we may contact you: e-mail, cell phone, work phone, home phone. May we text you? YES NO

Patient Employed by _____Occupation_____Work Phone _____

Name of Spouse, Parent, or Responsible Party(If patient is under 18, name of parents)_____

Address of Spouse, Parent, or Responsible Party_____DOB_____SSN_____

In case of emergency, who should be notified:_____Cell_____Relationship _____

Purpose of today's appointment_____

Insurance Information

Do you have dental insurance? Yes___No___ If yes, name of company_____

Name of policy holder_____Policy holder's SSN _____ Birthdate_____

Do you have secondary dental insurance? Yes___No___ If yes, name of company_____

Name of policy holder_____Policy Holder's SSN _____ Birthdate_____

Policy holder's employer _____ Phone _____

Please take your insurance card and driver's license to our front desk for duplication and verification.

Medical History

List medications to which you have reaction or are allergic. _____

_____

List medications you are currently taking. _____

_____

Have you ever had any of the following? Please circle "yes " or "no" for each condition and explain when response is "yes".

No	**Joint Replacement**	**Yes, Explain _____**	**No**	**Use of Tobacco Products**	**Yes, Types_____**
No	**Diabetes**	**Yes, Explain _____**	**No**	**Latex Allergy**	**Yes, Explain_____**
No	**AIDS/HIV**	**Yes, Details _____**	**No**	**Hepatitis/Liver Disease**	**Yes, Explain _____**
No	**Mitral Valve Prolapse**	**Yes, Explain _____**	**No**	**Pacemaker**	**Yes, When? _____**
No	**Pregnant**	**Yes, Due Date?_____**	**No**	**Heart Valve Replacement**	**Yes, Explain _____**
No	Gastric Ulcers	Yes, Explain_____	No	Epilepsy	Yes, Explain _____
No	Heart Murmur	Yes, Explain _____	No	Glaucoma	Yes, Explain_____
No	Rheumatic Fever	Yes, Explain _____	No	Hemophilia	Yes, Explain_____
No	Heart Surgery	Yes, Explain _____	No	Blood Disorders	Yes, Explain _____
No	Heart Disease	Yes, Explain _____	No	Herpes/Fever Blisters	Yes, Explain_____
No	Cancer	Yes, Explain _____	No	Kidney Disease	Yes, Explain _____
No	Radiation Treatment	Yes, Explain_____	No	Chemotherapy	Yes, Explain _____
No	Osteoporosis	Yes, Explain_____	**No**	**Dry Mouth**	**Yes, Explain_____**
No	Alzheimer's/dementia	Yes, Explain _____	No	Arthritis	Yes, Explain _____
No	Blood Transfusion	Yes, Explain _____	No	Stroke	Yes, Due Date_____
No	Blood Pressure Problems	Yes, Medicated?_____	No	STD	Yes, Type_____
No	Drug Abuse	Yes, Type_____	No	Tuberculosis	Yes, Explain _____
No	Parkinson's Disease	Yes, How long?_____	No	Blood-thinning Medication	Yes, Type _____

Name of Physician: _____Phone_____

What pharmacy do you prefer?_____Location_____Phone_____

Other medical conditions you have not indicated on page one: _____

Have you ever had problems with local anesthesia (numbing your teeth)? Yes____ No____ Explain _____

Have you had serious problems associated with dental treatment? Yes____ No_____ Explain_____

Please share with us how you heard about our practice? _____

Please inform us of the persons with whom we may share your health/dental /financial information :

Name:
_____Phone_____Relationship_____

Name:
_____Phone_____Relationship_____

I, THE UNDERSIGNED, CERTIFY AND ACKNOWLEDGE THE FOLLOWING:

- I assign all third party payments to this practice.
- I authorize this office to release any health information for the use of treatment, payment, and healthcare operations which includes insurance companies, specialists, and other healthcare providers and institutions.
- I acknowledge that I have access to a copy of the Practice's Notice of Privacy Practices on the website and in reception area.
- I am 18 years or older. If you are under 18, your parent or guardian must sign this form.
- I understand that x-rays and other diagnostic tests may be recommended and denial of these tests can result in undiagnosed and untreated oral conditions.
- I am the responsible party and assume responsibility for all the costs, regardless of insurance coverage. (Medicaid excluded)
- I assume responsibility for all costs of collections, including collection agency fees (max. 33.33%),finance charges, attorney fees, court costs, and other such related fees.
- I understand that dental insurance companies rarely cover 100% of all dental expenses.
- I understand how my insurance company will pay for services rendered at this practice. If not, ask us to find our for you.
- I understand that dental treatment carries with it some statistical risks even when performed with the utmost care.
- I understand that appointment times are reserved specifically for me and that any necessary changes should be finalized with the office two working days prior to the original appointment or a late cancellation fee may be charged.
- I have accurately answered all the questions and have read all the above information.
- I give consent for this practice to photograph any tissue, bone, or anatomical structures for purposes of diagnosis, treatment, patient education, presentation, or medical/dental research. I understand that any photographs or x-rays taken in this office may include identifiable facial characteristics.

Signature_____Relationship to Patient_____

Print name_____Date Signed _____

Patient Initials	Date	Patient BP		Patient Initials	Date	Patient BP	