# MARTIN MARGETIS,D.D.S.

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## Patient Information

### Personal

Name: Mr Ms. Mrs_____Date_____
Birthdate___/___/___Age_____Social Security Number_____
Person responsible for account_____
Home Address_____
_____ Phone #_____
E-mail Address_____ Cell Phone #_____
Employer_____ Occupation_____
Business address_____Work Phone#_____
Spouse's Name_____Employer_____
Occupation_____Phone #_____
Nearest relative NOT Living with You_____
Address_____Phone#_____
Whom May We Thank For Referring You?_____

### Dental Insurance

#### *Primary Dental Insurance*

Insurance Co. Name:_____
Insurance Co.Address:_____
_____
Insurance Co. Phone #_____Group # (Plan, local, or policy #)_____
Insured's Name_____Relation_____
Insured's Birthday_____/____/_____ Insured's SSN_____
Insured's Employer_____

#### *Secondary Dental Insurance*

Insurance Co. Name_____
Insurance Co. Address_____
Insurance Co. Phone #_____Group #(Plan, local, or policy#)_____
Insured's Name_____Relation_____
Insured's Birthday____/___/_____ Insured's SSN _____
Insured's Employer_____

**We will gladly assist in processing your dental insurance claims and estimate your co-payments. Any Remaining Balance from your primary insurance claims is due within 30 days**

In accordance with the Federal Truth-in-Lending Act which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply to this office. The responsible party agrees to

1. Pay the doctor at the time treatment or service is received or by previous arrangements
2. That if payments are extended beyond 90 days from the date of the first billing to pay 1.5% per month on the unpaid balance (annual percentage rate 18%) with a minimum charge of $.50 per month.
3. We accept Mastercard, Visa, American Express, or Discover

I / We agree to pay cost and/or reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection or suit.

### Missed Appointment Policy

In order to accommodate our patients and keep our schedule on time, there will be a fee assessed for broken appointments with less than 24-hour notice.

## Dental History

What is the reason for you dental visit today? _____

When was your last dental visit? _____

When was your last full series of X-rays? _____ bitewings? _____ Pan? _____

Have you ever had a negative experience with any dental treatment in the past?

If yes, explain _____

| | |
|---|---|
| Do you like your smile? | N Y |
| Do you like the color of your teeth? | N Y |
| Are you concerned with mouth odors? | N Y |
| Does food get caught between your teeth? | N Y |
| Have you ever been treated by a specialist? | N Y |
| Do your gums bleed? | N Y |
| Do you smoke or chew tobacco? | N Y |
| Do you have TMJ pain or discomfort? | N Y |
| Have you ever been told you have Periodontal or Gum Disease? | N Y |

## Medical History

Your current physical health is considered to be good fair poor

Are you currently under the care of a physician?

Why? _____ Who? _____ phone _____

Have you ever been hospitalized or had any major operations?

Explain _____

Have you ever had a a serious injury to the head or neck?

Explain _____

Are you currently taking any prescription or over the counter medications?

Please list _____

*WOMEN*: Are you pregnant N Y nursing N Y birth control N Y

## Please check any of the following that you have or have had in the past

| | | |
|---|---|---|
| __Heart trouble | __Lung Disease | __Artificial Valves |
| __Heart murmur | __Blood Disease | __Asthma/Hay Fever |
| __Heart attack | __Epilepsy | __Sinus Problems |
| __Mitral Valve Prolapse | __Thyroid Disease | __Liver Disease |
| __ Hepatitis A B C | __Radiation/Chemotherapy | __Diabetes |
| __ Artificial Joint Replacement | __Pacemaker | __ Stroke |
| __High/Low Blood Pressure | __Tumors/Cancer | __Kidney Problems |
| __Kidney/bladder trouble | __Arthritis | __AIDS/ HIV |

Is there ANY condition not listed we should know about? _____

**Are you on blood thinners?** _____ Drug name _____

## Are you allergic to any of the following?

| | | |
|---|---|---|
| __Penicillin | __Aspirin | __Dental Anesthesia |
| __Latex | __Sulfa | __Other_____ |

## Patient Agreement

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services, including the use of local anesthesia that I may need during diagnosis and treatment. **I also agree to pay for services rendered.**

_____

Signature Date