MARTIN MARGETIS, D.D.S.
FAMILY DENTISTRY

New Patient Form

PATIENT INFORMATION Date:_____

NAME: MR. MS. MRS. _____

DOB:____/____/____ SSN:_____ Person responsible for account: _____

Home Address: _____

E-Mail Address: _____

Home#: _____ Cell#: _____Work#: _____

Employer: _____Occupation:_____

Business Address: _____

Spouse's Name: _____ Employer: _____

Occupation: _____ Phone#:_____ Work#: _____

Nearest Relative NOT living with you _____

Address: _____

Whom may we thank for referring you? _____

Dental History

What is the reason for your dental visit today? _____

When was your last dental visit? _____

When was your last full series of x-rays? _____ Bitewings: _____ Pano: _____

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

If yes, please 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

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Dental Insurance

Primary Dental Insurance

Ins. Name: _____Ins Phone#: _____

Ins Address: _____

Subscriber Name:_____ DOB_____/_____/_____

Subscriber ID and or SSN: _____

Employers Name: _____Group Number: _____

Subscriber relation to patient: _____

Secondary Dental Insurance

Ins. Name: _____Ins Phone#: _____

Ins Address: _____

Subscriber Name:_____ DOB_____/_____/_____

Subscriber ID and or SSN: _____

Employers Name: _____Group Number: _____

Subscriber relation to patient: _____

We will gladly assist in processing your dental insurance claims and estimate your co-payments. Any remaining balance from your dental insurance claims is due within 30 days.

In accordance with the Federal Truth-in-Lending Ace 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 90days from the date of the first billing to pay 1.5% per month on the unpaid balance (annual percentage rate 18%) within 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 24hr notice.

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Medical History

Your current physical health is considered to be….. Good Fair Poor

Are you currently under the care of a physician? N Y

Why? _____ Physicians name and phone: _____

Have you ever been hospitalized or had any major operations? N Y

Explain _____

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

Explain _____

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

Please List: _____

WOMEN: Are you? Pregnant N / Y Nursing N / Y on Birth Control N / Y

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

__Heart trouble	__High/Low Blood Pressure	__Radiation/Chemotherapy	__Sinus Problems
__Heart murmur	__Kidney/bladder trouble	__Pacemaker	__Liver Disease
__Heart attack	__Lung Disease	__Tumors/Cancer	__Diabetes
__Mitral Valve	__Blood Disease	__Arthritis	__Stroke
__Hepatitis A B C	__Epilepsy	__Artificial Valves	__Kidney Problems
__Artificial Joint	__Thyroid Disease	__Asthma/Hay Fever	__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 _____
Is there ANYTHING not listed that you are allergic to? _____

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 the services rendered.**

Signature:_____ Date:_____