Recare_____ M.O._____ MIN

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McFADDEN FAMILY DENTISTRY, P.C.

PATIENT INFORMATION
(Please Print)

Name _____
Address _____
City & Zip _____
Home Phone _____
Cell Phone _____
Work Phone _____
Emergency Phone _____
Age _____ Birthdate _____
Sex _____ Marital Status ☐S ☐M ☐D ☐W
Employer _____
Occupation _____
Physician _____
Patient Soc. Sec. # _____
Previous Dentist _____
Whom may we thank for referring you to our office? _____

FINANCIAL RESPONSIBILITY

Name _____
Employer _____
Address _____
City & Zip _____
Work Phone _____
Insurance Co. _____
Secondary Ins. Co. _____
Group/Plan # _____
Soc. Sec. # _____
Birthdate _____

MEDICAL HISTORY OF PATIENT
(Please check those conditions that now or have ever pertained to you.) _____

Yes	No		Yes	No	
____	____	Heart murmur or congenital heart defect	____	____	Joint replacement (hip, knees...)
____	____	Heart surgery or heart disease	____	____	Convulsions or epilepsy
____	____	Rheumatic fever	____	____	Dizziness or fainting spells
____	____	Heart pacemaker	____	____	Stroke
____	____	Abnormal blood pressure high / low	____	____	Lung problems
____	____	Bleeding problems	____	____	Asthma
____	____	Diabetes	____	____	Tuberculosis (T.B.)
____	____	Kidney disease	____	____	Thyroid disease
____	____	Jaundice or liver disease	____	____	Glaucoma
____	____	Cancer or tumors	____	____	Ulcers/stomach disorders
____	____	Hepatitis	____	____	Arthritis
____	____	Venereal disease	____	____	Blood diseases, i.e. Anemia
____	____	AIDS or HIV positive	____	____	Sinus trouble
____	____	Allergic or sensitive to medication, drugs *(List below)* _____	____	____	Severe headaches
		_____	____	____	Females only: Are you pregnant?
		_____	____	____	Are you presently taking medication? *(If yes, please list and give reason for taking)*
		_____			_____
____	____	Are you currently under the care of a physician? *(List reasons)* _____			_____
		_____			_____
		_____	____	____	Do you take an asprin daily?
____	____	Do you smoke?			*Other medical problems not listed above*
____	____	Do you chew tobacco or snuff?			_____
					_____

REMARKS: *(Office use)*

Blood Pressure _____/_____ Cal. Yr. _____ Max. _____

Prev. _____ Ded. _____

Basic _____ Ded. _____

Major _____ Ded. _____

Ortho. _____ Ded. _____

OFFICE POLICY

1. Before treatment can be rendered, adequate radiographs of the teeth and oral structures must be taken.
2. Payment for professional service is required on the day the treatment is rendered.
3. Minors MUST be accompanied by a parent or legal guardian to all appointments.
4. Please give at least 24 hours notice if you cannot keep your appointment or a fee will be applied.

PERMISSION FOR TREATMENT AND PROMISE OF PAYMENT

This is to certify that I, the undersigned, consent to the performance of any and all procedures, and the use of any and all drugs that are agreed to be necessary or advisable. I also agree to accept full responsibility for the payment of all fees associated with those procedures and all costs incurred in the collection of those fees, including attorney fees, and 18% interest on overdue accounts.

Signed _____ Date _____

(Patient, or Parent if Minor under age 18)