Recare_____ M.O._____ MIN

_____

McFADDEN FAMILY DENTISTRY, P.C.

EMAIL Address: _____

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
_____	_____	HPV Vaccination	_____	_____	Severe headaches
_____	_____	Allergic or sensitive to medication, drugs	_____	_____	Females only: Are you pregnant?
		(List below) _____	_____	_____	Do you take an asprin daily?
		_____			_____
		_____			_____
_____	_____	Are you currently under the care of a physician?			_____
		(List reasons) _____			_____
		_____			
		_____			
_____	_____	Do you smoke?			
_____	_____	Do you chew tobacco or snuff?			

Medication List:

_____
_____
_____
_____
_____
_____

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)