CONFIDENTIAL PATIENT INFORMATION **Referred by**: ____________________ Date: _____/_____/_____

Patient's Name ______________________________ Birth Date: _____/_____/_____ SS# _____-_____-______

Address ______________________________ City __________________ State ______ Zip ________

Home # ______________ Cell #______________ Work # ______________ Employer __________________

Emergency Contact Name: ____________________ **Phone #** ____________________

Marital Status: M S D W Sex: M F **EMAIL:** ________________________________

** for practice-to-patient communication purposes only **

PERSON RESPONSIBLE FOR ACCOUNT

Name ______________________________ Relationship to Patient____________ SS#__________________

Address ______________________________ City ______________ State ______ Zip ________

Birth Date______________ Home #______________ Work # ______________ Cell #______________

INSURANCE INFORMATION **(Please Provide Insurance Cards and Forms when you arrive)**

"Primary" DENTAL Insurance Co. ____

Employee ______________Birth Date: _____/_____/_____Relationship _________ ID# or SS# ______________

Employer ______________________ Ins. Co. Phone #__________________Group#________________

"Secondary" DENTAL Insurance Co. ____

Employee ______________Birth Date: _____/_____/_____Relationship _________ ID# or SS# ______________

Employer ______________________ Ins. Co. Phone #__________________Group#________________

HEALTH INFORMATION

Have you ever had any of the following? **Check YES or NO for EACH:**

YES	NO		YES	NO		YES	NO	
☐	☐	Allergic to Latex	☐	☐	Psychiatric Care	☐	☐	Implants (any kind)
☐	☐	Heart Problems	☐	☐	Allergies to Medicine or Drugs	☐	☐	Heart Attack
☐	☐	High Blood Pressure	☐	☐	Arthritis	☐	☐	Sinus Problems
☐	☐	Circulatory Problems	☐	☐	Blood Disease	☐	☐	Asthma
☐	☐	Radiation Treatments	☐	☐	Mitral Valve Prolapse	☐	☐	Chemotherapy
☐	☐	Artificial Heart Valves	☐	☐	Rheumatic Fever	☐	☐	Thyroid Disease
☐	☐	Heart Pacemaker	☐	☐	AIDS or HIV Positive	☐	☐	Glaucoma
☐	☐	Diabetes	☐	☐	Stroke	☐	☐	Epilepsy or Seizures
☐	☐	Respiratory Disease	☐	☐	Ulcer	☐	☐	Hepatitis or Liver Disease
☐	☐	Heart Murmur	☐	☐	Cancer	☐	☐	Kidney Disease
☐	☐	Hemophilia	☐	☐	Headaches	☐	☐	Drugs to strengthen your bones
☐	☐	Artificial Joints	☐	☐	Bleeding Problems/Blood Thinners			

Do you need to be pre-medicated for any specific reason? ☐ Yes ☐ No If yes, why? ______________________________

Have you ever taken bisphonate drugs or any drug to strengthen your bones? ☐ Yes ☐ No (for example: Actonel, Boniva, Fosamax, Skelid, Didronel, Aredia, Zometa, Bonefos)

Are you under the care of a physician? ☐ Yes ☐ No For what condition(s)? ______________________________

(Women) Do you suspect you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your health? ______________________________

SIGNATURE ______________________________ **DATE:** _______/_______/_______

1. **I hereby authorize payment directly to Dr. McCann of the group insurance benefits otherwise payable to me.**
2. I understand that I am responsible for all costs of dental treatment.
3. I grant the right to the dentist to release my Dental / Medical and other information about my dental treatment to third party payors and / or other health professionals.
4. I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

*****24 hour notice is required for any cancellation or a broken appointment fee may be charged.*****

SIGNATURE ______________________________ **DATE:** _______/_______/_______

PATIENT NAME: ______________________________

CURRENT MEDICATION LIST

(Prescription AND Over the Counter) ☐ NONE

Medication	Dosage/Frequency	Medication	Dosage/Frequency

ALLERGIES

☐ NONE

Medication	Describe Nature of Reaction:

☐ NONE

List of All Doctor's Name	Type of Practice	Phone #

Pharmacy Name: ____________________

Phone Number: _____________________

Address: ___________________________________

Signature____ Date:_____/_____/_____

Please Handle Me With Care

Patient____ Date: _____/______/______

Please circle the number next to the statements that concern you or describe your situation.

1. I have not been to the dentist for a long time, and I feel worried about what you will say about my teeth and my oral hygiene.
2. My teeth are very sensitive.
3. Pain relief is a top priority for me.
4. I'm very anxious about injections.
5. I feel out of control in the dental chair (or I have an extreme problem with lying down).
6. I gag easily.
7. I hate the noise of dental instruments.
8. Please tell me about the treatment options and the ways these can be carried out.
9. I need to know that you will stop when I give a pre-agreed "stop" signal during treatment.
10. It would help me if you could explain to me what you are doing and why.
11. I have health problems that we need to discuss.
12. These are other issues I'd like to talk about that aren't covered on this form:

____

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____

NEW PATIENT SLIP **DATE: ______/______/______**

PATIENT NAME: ____ D.O.B.: ______/______/______

ADDRESS: ____ PH# (H): __________________

____ PH# (C): __________________

PARENT NAME: ____ PH# (W): __________________
(IF MINOR)

ARE YOU IN PAIN? ____

HOW LONG SINCE LAST VISIT TO DENTIST? ____

HOW DID THAT LAST VISIT GO…OR ANY SPECIFIC **CHIEF CONCERN?**

____

____

BRINGING XRAYS/RECORDS FROM PREVIOUS DENTIST?_____________________________________

DO YOU RECALL THE DATE OF LAST XRAYS TAKEN? NO IF YES, DATE: ______/______/______

ANY OTHER PREVIOUS UNPLEASANT DENTAL EXPERIENCES THAT YOU WANT TO MENTION?

____

____

HOW DID YOU HEAR ABOUT OUR OFFICE? ____

INSURANCE: ____

EMAIL ADDRESS: ______________________________________

WE LOOK FORWARD TO SEEING YOU!