Macy Family Dentistry

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Patient Name: _____Cell:_____ Date: _____

Address:_____City:_____State:_____Zip:_____

☐ Male ☐ Female | ☐ Married ☐ Single ☐ Child ☐ Other | Social Security #: _____

Birth Date: _____Phone (Home): _____ (Work): _____ (Other):_____

Date of Last Dental Visit:_____ Reason for today's visit:_____

Date of Last Cleaning:_____Last X-rays: Bitewings:_____Panoramic/Full Mouth Series:_____

What would you like us to do today?_____

Is there anything you would like to change about your smile?_____

☐ Email:_____Please send email/text reminders and information to the email provided. Macy Family Dentistry does not send spam email or texts. We do not share email or text with other parties. These are for important office reminders and appointment information only.

☐ Please send me **Paperless Billing** to the email listed above.

Insurance Information

Does patient have dental insurance? ☐ Yes ☐ No Insurance company: _____

Name of insured/subscriber:_____ Relationship to Patient:_____

Insured/subscribers date of birth: _____

Address of the insured/subscriber:_____

Insured's ID # or Social Security #:_____Group #:_____

Is patient covered by secondary dental insurance? ☐ Yes ☐ No If yes, please fill information below:
Name of the secondary insured/subscriber:_____ Relationship to Patient:_____

Secondary insured/subscriber date of birth: _____Address:_____

Insured's ID # or Social Security #:_____Group#:_____

Consent for Services

In fairness to all patients, this office charges for missed appointments without 48 hrs. prior notice. You are responsible to know your own dental insurance and benefits. X-rays and fluoride treatments will be done at the doctors discretion. I agree to be responsible for all charges. Patients who have dental insurance authorize payments to be made directly to the doctor, and the release of any information relating to claims. We will be glad to submit claims for you; however you are ultimately responsible for the charges.

I grant my permission for the office staff to contact me by phone calls, message on answering machine, text, emails or postcards regarding appointments.

HIPAA CONSENT: I have seen and been given the opportunity to review this office's Notice of Privacy Practices. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

I have read the above conditions of treatment and payment and agree to their content.

_____**Date:**_____ **Relationship to patient:**_____

Signature of patient, parent or guardian

If you were referred by someone, whom may we thank for referring you? _____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No If yes, please explain:_____

_____

Primary Care Physician: _____ Phone:_____

Specialty Physicians: _____ Phone:_____

Do you have, or have you had any health problems or surgeries, such as joint replacements? ☐ Yes ☐ No If yes, please explain:_____

_____**Dr. Initials** _____

Do you currently have or have you ever had any of the following? Please fill in all applicable:

Heart/Vascular	Digestive System	Nervous System
Heart Disease	Hepatitis Type_____	Dizziness
Heart Murmur	Stomach Problems	Epilepsy
High Blood Pressure	Ulcers	Fainting
Pacemaker	Crohn's/Ulcerative Colitis	Nervous Disorders
Blood	**Cancer**	Stroke
AIDS/HIV	Type/Treatment: _____	**Endocrine**
Anemia	Radiation Treatment	Diabetes HbA1c_____
Anticoagulants (Blood Thinners)	Chemotherapy	Type I
Blood Disease	Tumors	Type II
Excessive Bleeding	**Allergies**	Thyroid Problems
Respiratory	Hay Fever	**Mental Health**
Asthma	Codeine Allergy	Chemical Dependency
Respiratory Problems	Penicillin Allergy	Eating Disorder
Tuberculosis	Latex Allergy	Mental Disorders
Bone	Other:	Tobacco Habit
Arthritis		Anxiety
Artificial Joint		Other:
Medications for Bones/Osteoporosis	**Other**	
Rheumatism	Surgeries–Past/Future:	**Head/Neck/Eyes**
Urinary		Glaucoma
Venereal Disease		Head Injuries
Kidney Disease	Pregnant: Due Date _____	Sinus Problems

Current Medications (OTC, Rx, Homeopathic)	Reasons for Taking