DEMILLE MACKAY dental

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____
MARITAL STATUS: { } MARRIED { } SINGLE { } CHILD { } OTHER_____
BIRTHDAY: _____ SOC SEC# _____DR. LICENSE/ST#:_____
ADDRESS: _____ HOME PHONE# _____
CITY:_____STATE:_____ ZIP:_____CELL PHONE# _____
PATIENT EMPLOYER: _____ WORK PHONE# _____
EMERGENCY CONTACT: _____PHONE # _____
*****WHOM MAY WE THANK FOR REFERRING YOU?** _____
EMAIL ADDRESS FOR COUPONS PROMOTIONS REMINDERS & UPDATES:

RESPONSIBLE PARTY

RESPONSIBLE FOR ACCOUNT: _____
RELATION TO PATIENT: _____
BIRTHDAY: _____ SOC SEC#:_____ DR. LICENSE #: _____
ADDRESS: _____ HOME PHONE#: _____
CITY: _____ STATE:_____ZIP:_____CELL PHONE#: _____
EMPLOYER: _____ WORK PHONE#: _____

DENTAL INSURANCE INFORMATION

SUBSCRIBER NAME: _____**SUBSCRIBER DOB**:_____
SUBSCRIBER'S ADDRESS:_____
CITY:_____STATE:_____ZIP: _____
RELATION TO PATIENT: _____SUBSCRIBERS SOC SEC#:_____
DENTAL INSURANCE PROVIDER: _____
INSURANCE ADDRESS: _____
CITY: _____STATE: _____ ZIP: _____
INSURANCE PHONE #:_____ EMPLOYER:_____
SUBSCRIBER ID#: _____ **GROUP POLICY #:** _____

SECONDARY INSURANCE INFORMATION

SUBSCRIBER NAME: _____**SUBSCRIBER DOB:**_____
SUBSCRIBER ADDRESS: _____
CITY:_____STATE:_____ZIP:_____
RELATION TO PATIENT: _____SUBSCRIBER SOC SEC#: _____
DENTAL INSURANCE PROVIDER: _____
INSURANCE ADDRESS: _____CITY_____ST:_____ZIP:_____
SUBSCRIBER ID# _____**GROUP POLICY#:** _____

PATIENT MEDICAL HISTORY

PHYSICIAN: _____OFFICE PHONE _____
Have you ever taken any of the group drugs referred as a "fen-phen?" { } Yes { } No

ALLERGIES **MEDICATIONS**

[ ]Aspirin	[ ]Local Anesthetic
[ ]Barbiturates (Sleep Pills)	[ ]Penicillin
[ ]Codeine	[ ]Sulfa
[ ]Iodine	[ ]Other: _____

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Phone #: _____

PLEASE CONTINUE THIS FORM ON THE REVERSER SIDE.

PATIENT MEDICAL HISTORY CONTINUED

Check if you have any of the following:

[ ] Aids/HIV	[ ] Emphysema	[ ] Rheumatic Fever
[ ] Anemia	[ ] Epilepsy	[ ] Scarlet Fever
[ ] Arthritis, Rheumatism	[ ] Fainting or dizziness	[ ] Shortness of Breath
[ ] Artificial Heart Valves	[ ] Glaucoma	[ ] Sinus Trouble
[ ] Artificial Joints	[ ] Headaches	[ ] Skin Rash
[ ] Asthma	[ ] Heart Murmur	[ ] Special Diet
[ ] Back Problems	[ ] Heart Problems	[ ] Stroke
[ ] Bleeding abnormally, with Extractions or surgery	[ ] Hepatitis Type _____	[ ] Swollen Feet/Ankles
	[ ] Herpes	[ ] Swollen Neck Glands
[ ] Blood Disease	[ ] High Blood Pressure	[ ] Thyroid Problems
[ ] Cancer	[ ] Mitral Valve Prolapse	[ ] Tonsillitis
[ ] Chemical Dependency	[ ] Mental Disorders/Conditions	[ ] Tuberculosis
[ ] Chemotherapy	[ ] Nervous Problems	[ ] Tumor or growth on head/neck
[ ] Circulatory Problems	[ ] Pacemaker	[ ] Ulcer
[ ] Congenital Heart Disease	[ ] Psychiatric Care	[ ] Venereal Disease
[ ] Cortisone Treatments	[ ] Radiation Treatment	[ ] Unexplained weight loss
[ ] Cough, Persistent/Bloody	[ ] Respiratory Disease	[ ] Traveled out side of the US
[ ] Diabetes		Dates: _____
		[ ] **None of the above**

CONSENT TO PROCEED WITH TREATMENT

I AUTHORIZE Drs. David MacKay and Christopher DeMille and/or such associates or assistants as they may designate to perform those procedures as many be deemed necessary or advisable to maintain my dental health or the dental health of any individual for which I have responsibility, including administration of any sedative (including nitrous oxide), analgesic, therapeutic, and pharmaceutical agents, including those related to restorative, palliative, therapeutic, or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but not limited to, bruising hematoma, cardiac stimulation, and temporary numbness and muscle soreness.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of all foregoing procedures have been explained to me; if necessary I have been given the opportunity to ask questions.

FINANCIAL POLICY

- I understand that DeMille MacKay Dental will bill my insurance company as a courtesy, but that the amount incurred is ultimately my responsibility should my insurance company not pay. I also understand that it is my responsibility to direct all inquires regarding unpaid claims to my insurance company and to contact them myself.
- Broken appointment without 24 hour notice will result in a thirty dollar no show fee per half hour.
- Payment is due at the time of service unless prior arrangements have been made (i.e. insurance, payment plan)
- I agree to pay all costs and reasonable attorney fees if a suit or collection agency is instituted hereunder to collect monies owned by me. 40% of my balance will be added to the overall balance if a collection agency is used.
- I grant permission to you or your assignee to telephone me at my home or work place to discuss matters related to this form.
- I authorize assignment or payment of all dental benefits to which I or other family members are entitled, including private or group dental benefits otherwise payable to the undersigned, to DeMille Mackay Dental.
- _____ _____ _____

  Signature Date Relation to Patient