Mark McGee D.D.S., PC

Personal Information

Mr./Mrs./Ms./Miss (Last)______________________________(First)_________________________(MI)_____________

What name shall we call you?_____________________________ Date of Birth________________________________

Home address_______________________________________City__________________State__________Zip_______

E-mail address_________________________________ Home phone______________ Cell phone_________________

Driver Lic#____________________________________State___________SS#___________-_________-___________

Employer______________________________ Occupation_________________________ Work phone______________

Address__________________________________ City______________________ State__________ Zip___________

Spouse Name__________________________________ Children(s) names_____________________________________

Parent /guardian name if minor____

Emergency contact_____________________________ Relation__________________ Telephone_________________

Who may we thank for referring you?____

Insurance Information

Name of insured________________________________ Relationship to patient________________________________

Birth date____________________ SS#__________-_________-_________ Date employed_____________________

Name of employer_________________________________ Work phone#_______________________________________

To avoid any misunderstanding concerning your dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We do not render services on the basis that the insurance companies will pay our fees unless a pre-determination of benefits has been established. We will assist you in filing all insurance forms. Payment is due when services are rendered unless other arrangements have been made. If you must change a scheduled appointment, please inform us as soon as possible. If we are not notified before 3:00 PM the working day prior to your appointment, then we may regrettably charge your account.

I hereby authorize Dr. McGee to take radiographs, study models, photographs or any other diagnostic aids deemed necessary to make a thorough diagnosis for my dental needs. I also authorize the doctor to prescribe any and all forms of medication, and to perform any therapy that may be indicated and agreed upon.

I further authorize the release of any information including the diagnosis and records of any treatments or examinations rendered to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitating the billing and reimbursement directly to the dentist for insurance benefits under which I am entitled. I understand the responsibility for payment for serviced rendered for myself and my family are due and payable at the time the service is rendered.

Signature of patient or responsible party ____________________________________ Date_________________

Please circle either Y (YES) or N (NO) as applicable:
Do you have or have ever had any of the following?

HYPOGLYCEMIA	(Y) OR (N)	PROSTHETIC VALVES	(Y) OR (N)
DIABETES	(Y) OR (N)	ARTIFICIAL JOINTS OR IMPLANTS	(Y) OR (N)
HEART ATTACK	(Y) OR (N)	STROKE	(Y) OR (N)
HEART TROUBLE	(Y) OR (N)	OSTEOPOROSIS	(Y) OR (N)
HAY FEVER, ASTHMA, ALLERGIES	(Y) OR (N)	SINUS PROBLEMS	(Y) OR (N)
CIRCULATORY PROBLEMS	(Y) OR (N)	HEART MURMUR	(Y) OR (N)
HEPATITIS	(Y) OR (N)	MITRAL VALVE PROLAPSE	(Y) OR (N)
JAUNDICE	(Y) OR (N)	RHEUMATIC FEVER	(Y) OR (N)
LUNG PROBLEMS	(Y) OR (N)	ANEMIA	(Y) OR (N)
TUBERCULOSIS	(Y) OR (N)	BLOOD DISORDER	(Y) OR (N)
EPILEPSY, SEIZURE	(Y) OR (N)	EXCESSIVE BLEEDING	(Y) OR (N)
BLOOD TRANSFUSIONS	(Y) OR (N)	FAINTING, BLACKOUTS	(Y) OR (N)
FACIAL OR HEAD INJURIES	(Y) OR (N)	NERVOUS DISORDER	(Y) OR (N)
RADIATION	(Y) OR (N)	HEADACHES, MIGRAINES	(Y) OR (N)
CHEMOTHERAPHY	(Y) OR (N)	KIDNEY PROBLEMS	(Y) OR (N)
MALIGNANCIES	(Y) OR (N)	GLAUCOMA, EYE PROBLEMS	(Y) OR (N)
CANCER	(Y) OR (N)	ULCERS	(Y) OR (N)
AIDS	(Y) OR (N)	DIGESTIVE PROBLEMS	(Y) OR (N)
HIV POSITIVE	(Y) OR (N)	HISTORY OF EATING DISORDERS	(Y) OR (N)
ARTHRITIS	(Y) OR (N)	ARE YOU PREGNANT NOW?	(Y) OR (N)
SPINAL FUSION	(Y) OR (N)	LATEX ALLERGY	(Y) OR (N)
HIGH BLOOD PRESSURE	(Y) OR (N)	LOW BLOOD PRESSURE	(Y) OR (N)

Do you have allergies to any of the medications listed below? (Please circle)

(ASPIRIN) (CODEINE) (ANESTHETICS) (XYLOCAINE) (NOVOCAINE) (SEDATIVES)
(PENICILLIN) (ERYTHOMYCIN) (LIDOCAINE) OTHER ANTIBIOTICS_______________________________

Have you noticed any of the following?

Discomfort in face, head, neck, jaw	(Y) OR (N)	Jaw clicking or popping	(Y) OR (N)
Loose teeth	(Y) OR (N)	Swelling lumps in mouth	(Y) OR (N)
Food caught between teeth	(Y) OR (N)	Bleeding or sore gums	(Y) OR (N)
Sensitivity to sweets, hot or cold	(Y) OR (N)	Recurring sore in or around the mouth	(Y) OR (N)
Teeth tender when chewing	(Y) OR (N)		

Name & Phone # of Physician: ____

Have you been hospitalized in the last year? If yes explain, ____

Please list any drugs currently being taken: ____

____

Do you consume alcohol or use tobacco? Y/N In what quantities?____________________________________

Reason for this dental visit ______________________________ Date of last dental visit______________

Have you ever been treated by a periodontist, orthodontist or endodontist? Y/N If yes explain:

____Date of last x-rays___________________

Are you happy with the appearance of your teeth? Y/N

THE INFORMATION ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____________________________________ DATE: __________________________