IMPORTANT
PLEASE READ

In order to successfully submit these forms online it will require you to use the Adobe Acrobat Reader plugin for your web browser. If you do not have that you can click the link below and install it.

If you attempt to fil out these forms and submit them online using Adobe Acrobat Reader itselft, or another similar utility, this will fail.

However, if you don't wish to install the plugin, you can fill out the form, print it and bring the forms with you 15 minutes prior to your scheduled appointment.

Thank you for your cooperation.

Marcos & Marcos DDS

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New Patient Form

About You

Today's Date: Email Address:
Last Name: First Name:
I prefer to be called: Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated
Birthdate: Age: Soc. Sec. #: Gender: ❑Female ❑Male
Home Address:
City: State: Zip:
Home Phone: Cell Phone: Work Phone: Ext:
Driver's License #: Whom may we thank for referring you?
Best way to reach you during office hours? ❑Home ❑Work ❑Cell ❑Email ❑Regular Mail
Other family members seen by us:
Employer: How long there: Occupation:
Employer's address:
City: State: Zip:

In Case Of Emergency, Whom Should We Contact:

His / Her Name: Relation:
Work Phone: Cell Phone: Home Phone:

Spouse Information

His / Her Name: Birthdate: Soc. Sec.#:
Employer:
Work Phone: Ext: Driver's License #:

Insurance Information

Primary Insurance:
Dental Coverage? ❑Y ❑N Orthodontic Coverage? ❑Y ❑N Medical Coverage? ❑Y ❑N
Insurance Co. Name: Phone #: Group:
Insurance Co. Address:
City: State: Zip:
Insured's Name: Insured's Soc. Sec. #:
Insured's Birthdate: Relation: Insured's Employer:
Employer's Address:
City: State: Zip:

Secondary Insurance: (if applicable)
Dental Coverage? ❑Y ❑N Orthodontic Coverage? ❑Y ❑N Medical Coverage? ❑Y ❑N
Insurance Co. Name: Phone #: Group:
Insurance Co. Address:
City: State: Zip:
Insured's Name: Insured's Soc. Sec. #:
Insured's Birthdate: Relation: Insured's Employer:
Employer's Address:
City: State: Zip:

The above information is true and correct to the best of my knowledge. I authorize and give consent to perform dental service agreed between the dentist(s) and myself and/or to be necessary or advisable, including the use of local anesthesia and other medications as indicated. I understand that, regardless of insurance coverage, I am responsible for payment of services rendered and that a finance charge of 23% APR or 1.92% per month will be applied to accounts past due 90 days or more.

Patient Signature: Date:

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HEALTH HISTORY

DENTAL HISTORY

Why have you come to the dentist today?

Are your teeth sensitive to heat, cold or anything else?

Are you currently in pain? ❑Y ❑N How is your dental health? ❑Good ❑Fair ❑Poor

Do you require antibiotics before dental treatment? ❑Y ❑N

Do you floss daily? ❑Y ❑N Brush daily? ❑Y ❑N

Type of bristles on your toothbrush? ❑Hard ❑Medium ❑Soft

Do your gums bleed? ❑Y ❑N Do your gums itch? ❑Y ❑N

Ever had periodontal disease? ❑Y ❑N Do you have mobility in your teeth? ❑Y ❑N

Do you still have wisdom teeth? ❑Y ❑N Previous / Present Dentist?

Last visit date? Would you like fresher breath? ❑Y ❑N Whiter teeth? ❑Y ❑N

Are you happy with your smile? ❑Y ❑N If not, what would you change?

MEDICAL HISTORY

Do you have a personal physician? ❑Y ❑N Your current health condition? ❑Good ❑Fair ❑Poor

Are you currently under the care of a physician? ❑Y ❑N Explain:

Physician's name:

Physician's address:

City: State: Zip:

Phone: Date of last visit?

Do you smoke or use tobacco in any form? ❑Y ❑N

Have you ever taken Phen-Fen, Redux or Pondimin? ❑Y ❑N

Have you ever taken Bis-Phosphate medications (i.e. Aredia and Zometa)? ❑Y ❑N

For Women: Are you taking birth control pills? ❑Y ❑N Are you pregnant? ❑Y ❑N ❑Unsure

Week #: Are you nursing? ❑Y ❑N

Have you ever experienced any of the following?

Y	N		Y	N		Y	N		Y	N		Y	N	
❑	❑	Abnormal Bleeding	❑	❑	Colitis	❑	❑	Hay Fever	❑	❑	Liver Disease	❑	❑	Shingles
❑	❑	Alcohol Abuse	❑	❑	Congenital Heart Defect	❑	❑	Headaches	❑	❑	Low Blood Pressure	❑	❑	Sickle Cell Disease
❑	❑	Anemia	❑	❑	Diabetes	❑	❑	Heart Attacks	❑	❑	Lupus	❑	❑	Sinus Problems
❑	❑	Arthritis	❑	❑	Difficulty Breathing	❑	❑	Heart Murmur	❑	❑	Mitral Valve Prolapse	❑	❑	Steroid Therapy
❑	❑	Artificial Bones/Joints	❑	❑	Drug Abuse	❑	❑	Heart Surgery	❑	❑	Pacemaker	❑	❑	Stroke
❑	❑	Artificial Valves	❑	❑	Emphysema	❑	❑	Hemophilia	❑	❑	Persistent Cough	❑	❑	Thyroid Problems
❑	❑	Asthma	❑	❑	Epilepsy	❑	❑	Hepatitis	❑	❑	Psychiatric Problems	❑	❑	Tonsillitis
❑	❑	Blood Transfusion	❑	❑	Ever Hospitalized	❑	❑	Herpes	❑	❑	Radiation Treatment	❑	❑	Tuberculosis (TB)
❑	❑	Cancer	❑	❑	Fainting Spells	❑	❑	High Blood Pressure	❑	❑	Rheumatic Fever	❑	❑	Ulcers
❑	❑	Chemotherapy	❑	❑	Fever Blisters	❑	❑	HIV+ / AIDS	❑	❑	Scarlet Fever	❑	❑	Venereal Disease
❑	❑	Chicken Pox	❑	❑	Glaucoma	❑	❑	Kidney Problems	❑	❑	Seizures			

Please list any serious medical condition(s) that you have experienced:

Are you taking any perscription or over the counter drugs? ❑Y ❑N

If yes, please list:

Are you allergic to any of the following?

❑Aspirin ❑Barbiturates ❑Codeine ❑Dental Anesthetics ❑Erythromycin ❑Jewelry/Metals

❑Latex ❑Penicillin ❑Sedatives ❑Sulfa Drugs ❑Tetracycline ❑Other:

I confirm that the medical history above states my past and present medical conditions.

Signature: Date:

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Our Financial Policies

Welcome to Marcos & Marcos DDS. It is our pleasure to have you as our patient. Our commitment is to provide you with the best possible dental care and to keep you informed of treatment recommendations and financial obligations.

If you have dental insurance, we will be glad to help you receive your maximum allowed benefits.

The following is our office payment policy:

- Payment is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, Discover and American Express.
- If you are a patient with insurance, it is important to remember that your insurance plan is a contract between you, your employer and the insurance company. This contract is in no way a binding obligation between the dental insurance company and Marcos & Marcos DDS.
- Our fees generally fall within the accepted range of the maximum allowance determined by each insurance carrier. This applies only to companies which pay a percentage of “usual, customary and reasonable” rates. This does not apply to companies which reimburse based on an arbitrary “schedule” of fees.
- After your initial exam, you will receive a treatment plan which estimates your portion of payment. If we estimate and collect your co-payment and the insurance underpays or denies a benefit, you are responsible for the remaining balance.
- While discouraged, a submitted insurance pre-estimate may be sent to your insurance company upon your request. The fee for this estimate is $50.00.
- Not all services are covered in all insurance contracts. Insurance companies arbitrarily select certain procedures they do not cover, based upon the premium/contract arranged by your employer.
- In order for us to help you process your insurance claim for your reimbursement, please bring all insurance information with you. Also, please call your dental insurance carrier to expedite claims if a claim is not paid within 30 days, as the law requires.

Returned checks and outstanding balances over 90 days are subject to bank fees, collection fees and an interest rate charge of 23% APR or 1.92% per month. There is also a charge for broken appointments and those canceled without 2 business days notice. Please remember that the staff sets aside a designated amount of time for your particular type of treatment. If you miss an appointment without notifying our office, you will be required to pay 50% of the value of your next appointment (non-refundable) before scheduling. If you miss two scheduled appointments without notifying our office, you will be dismissed. We appreciate your understanding of how important keeping appointments is to the doctors and our other patients.

We hope by presenting our policies to you in the beginning, we will avoid any misunderstandings and have more time to dedicate to your dental care. If you have any questions regarding the above information or insurance coverage, please do not hesitate to ask. We are here to help you!

Patient Signature: _____ Date: _____

Submit