Kevin D. Marshall, D.M.D.
9 Post Road, Suite M5
Oakland, NJ 07436
(201) 644-0857

PATIENT INFORMATION

DATE .....

NAME: ……
ADDRESS: ……
CITY: ……STATE……ZIP……..
BIRTHDATE: ……/……/…… AGE: …… SEX: [_] MALE [_] FEMALE
HOME PHONE: …… WORK PHONE: …….. CELL PHONE: …….
SOCIAL SECURITY NO. …… EMAIL ADDRESS: ……
[_] SINGLE [_] MARRIED [_] DIVORCED [_] WIDOWED [_] SEPARATED
IN CASE OF EMERGENCY CONTACT: ……
RELATION: …… PHONE: ……
WHOM MAY WE THANK FOR REFERRING YOU? FAMILY MEMBER [_] STAFF [_] PATIENT [_]
WEBSITE [_] CHURCH BULLETIN [_] WALKING BY [_]

MEDICAL HISTORY

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? Y N
PHYSICIAN'S NAME: …… PHONE: ……
PHARMACY: …… PHONE: ……

DO YOU TAKE ANY PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS? Y N
PLEASE LIST: ……
……

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y N	PENICILLIN	Y N	ASPIRIN	Y N	CODEINE
Y N	TETRACYCLINE	Y N	NOVOCAINE	Y N	LATEX

Y N OTHER ALLERGIES ……

DOES YOUR MEDICAL HISTORY INCLUDE ANY OF THE FOLLOWING?

Y N	ALCOHOL OR DRUG ABUSE	Y N	ASTHMA
Y N	ANEMIA	Y N	CANCER/CHEMOTHERAPY
Y N	DIABETES	Y N	EPILEPSY/SEIZURES
Y N	GLAUCOMA	Y N	HEART ATTACK
Y N	HEART SURGERY	Y N	HIGH BLOOD PRESSURE
Y N	HEART MURMUR	Y N	MITRAL VALVE PROLAPSE
Y N	HEPATITIS	Y N	HEMOPHILIA
Y N	HIV+/AIDS	Y N	KIDNEY DISEASE
Y N	LIVER DISEASE	Y N	LUNG CONDITION/EMPHYSEMA
Y N	RHEUMATIC FEVER	Y N	THYROID PROBLEMS
Y N	TUBERCULOSIS	Y N	ULCERS/COLITIS
Y N	VENEREAL DISEASE	Y N	ARTIFICIAL HIP OR JOINT

Y N CIGARETTES, CIGARS, PIPE OR SMOKELESS TOBACCO ……

FOR WOMEN: ARE YOU TAKING BIRTH CONTROL PILLS? Y N
ARE YOU PREGNANT? Y N WEEK# _____ ARE YOU NURSING? Y N

IS THERE ANY OTHER MEDICAL CONDITION WE SHOULD BE AWARE OF? ……
……

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DENTAL HISTORY

CC: WHY DID YOU COME TO THE DENTIST TODAY? ……

Y N DO YOU HAVE ANY SENSITIVE TEETH?
Y N DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?
Y N DO YOU GAG EASILY?
Y N DO YOU CLENCH OR GRIND YOUR TEETH DURING THE DAY OR NIGHT?
Y N DO YOU HAVE ANY LOOSE TEETH?
Y N ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH?

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

…….. ……..
PATIENT or GUARDIAN SIGNATURE DATE

RESPONSIBLE PARTY AND EMPLOYMENT INFORMATION

PERSON RESPONSIBLE FOR PAYMENT: ……
ADDRESS: ……..
RELATIONSHIP TO PATIENT: …… PHONE: ……
EMPLOYER NAME: ……..
EMPLOYER ADDRESS: ……..
……

DENTAL INSURANCE INFORMATION

1. PRIMAY DENTAL INSURANCE
   INSURANCE COMPANY NAME: …….
   GROUP NUMBER: …… PHONE: ……
   EMPLOYEE/INSURED NAME: …… RELATION: …….
   EMPLOYEE/INSURED SS#: …….. BIRTHDATE: ……
   EMPLOYER: ……..
   EMPLOYER ADDRESS: ……

2. SECONDARY DENTAL INSURANCE
   INSURANCE COMPANY NAME: ……..
   GROUP NUMBER: …… PHONE: ……
   EMPLOYEE/INSURED NAME: …… RELATION: …….
   EMPLOYEE/INSURED SS#: …… BIRTHDATE: ……..
   EMPLOYER: ……
   EMPLOYER ADDRESS:……

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In order to avoid any confusion about the payment policies of this office or the utilization of your dental insurance, we have assembled the following FINANCIAL AGREEMENT to answer any questions that may arise. Please read the following carefully. Your signature will acknowledge your understanding the agreement. This policy also applies to your dependents under the age 18.

Scheduled Appointments: All appointments are coordinated so that we can devote our undivided attention to you when you are here. Our goal is to do our best to see you on time. We are committed to being available to only you. Please understand that when we schedule you an appointment, that time is reserved exclusively for you. This time is very valuable and if it's not used wisely or respected, it is a great loss for everyone. If you must modify/reschedule your appointment, we REQUIRE at least one business day notice prior to your scheduled time.

A Broken Appointment Fee will be enforced for any missed appointments.
A fee of $75 per hour will be assessed for appointments failed.

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Payment Arrangements: In an effort to make needed services more affordable, we have a policy in effect that requires payment when services are rendered. This plan helps reduce cost and overhead without diminishing the quality of our services. We accept the following payment methods:

Cash, Checks, MasterCard, Visa, Discover

and Care Credit (for extended payments)

Insurance Policy: We are happy to accept your dental insurance and work with you and your insurance company. So that we may file your insurance claims correctly, we ask all patients to complete our Dental Insurance Information Form We will compute your estimate of your copayment as per your benefits provided to us by your insurance carrier. At each visit **your CO-PAYMENT/DEDUCTIBLES ARE DUE AT THE TIME SERVICES ARE RENDERED.** Please remember that the final responsibility for any balance due rests upon the patient.

.I understand that any unpaid balance after 60 days is charged a yearly financial charge of 18%. I further understand that this finance charge is equal to 1.5% of my outstanding balance per month. I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If our office must take additional steps to collect my account, I will pay all cost of collection, including court cost and attorney's fees incurred by our office.

I have carefully read and understand appointment and cancellation notice, payment arrangement procedures and Insurance policy. To ensure a successful outcome, I agree to cooperate with these guidelines.

Signature: _____ Date: _____