MAUCK & RICCI, DDS.

PATIENT INFORMATION

Date ______________________

First Name ______________________ Last Name ______________________ Middle Initial ________

Preferred Name ______________________ Address ______________________

City, State, Zip ______________________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Domestic Partner

Birth Date ______________ Social Security # ______________

Employer ______________ Occupation ______________

Who may we thank for referring you to our office? ______________________

E-mail Address ______________________

Drivers License # ______________

Emergency Contact ______________________ Phone ______________

Spouse ______________ Spouse Employer ______________ Spouse Employer Ph. # ______________

RESPONSIBLE PARTY INFORMATION

Who is responsible for the account? ______________________

Relationship to Patient ______________ Birth Date __________ Drivers License # __________

Social Security # ______________ E-mail Address ______________

Address ______________ Phone (cell/hm) ______________ Office: ______________

City, State, Zip ______________________

Employer ______________ Occupation ______________

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured ______________________ Relationship to Patient ______________

Insured's Birth Date ______________ Insured's Social Security # ______________

Employer ______________ Date Employed __________ Occupation __________

Insurance Company ______________________

Claims/Insurance Company Address ______________________

City, State, Zip ______________________

Group # ______________ Subscriber ID# ______________

SECONDARY DENTAL INSURANCE INFORMATION

Name of Insured ______________________ Relationship to Patient ______________

Insured's Birth Date ______________ Insured's Social Security # ______________

Employer ______________ Date Employed __________ Occupation __________

Insurance Company ______________________

Claims/Insurance Company Address ______________________

City, State, Zip ______________________

Group # ______________ Subscriber ID# ______________

CONSENT

I understand that responsibility for payment of dental services in this office for myself and my dependents is mine; due and payable at the time services are rednered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). Insurance claims are filed as a courtesty, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance. I also assign all benefits to Name of Provider. I authorize the submission of claims without obtaining my signature on each and every claim submitted. I give an authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my dentist. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize this provider and its employees, agents and assignees to contact me via e-mail, text messaging and to my cellular devices.

Signature ______________________ Date ______________

Dentist Signature ______________________ Date ______________

MEDICAL HISTORY

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

- ☐ A-FIB
- ☐ AIDS/HIV Pos.
- ☐ Alcoholism
- ☐ Allergies-Seasonal
- ☐ Alzheimer/Dementia
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis/Rheumatoid Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints (hip, knee, etc.)
- ☐ Asthma
- ☐ Bishphosphonate Therapy
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Congenital Heart Lesions
- ☐ Diabetes
- ☐ Cosmetic Surgery
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Emphysema/COPD
- ☐ Epilepsy or Seizures
- ☐ Fever Blisters
- ☐ Gerd
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Disease or Attack
- ☐ Heart Murmur
- ☐ Heart Peacemaker/Stent
- ☐ Heart Surgery
- ☐ Hemophilia (bleeding problems)
- ☐ Hepatitis A (infectious)
- ☐ Hepatitis B (serum)
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Trouble
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ MS
- ☐ Nervousness
- ☐ Osteoporosis
- ☐ Pain in Jaw Joint
- ☐ Pregnant (presently)
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Sinus Trouble
- ☐ Sleep Apnea/C-pap
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tobacco (any form)
- ☐ Tuberculosis (TB)
- ☐ Ulcers

	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐

Explain: ______________________________

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LIST ALL MEDICATIONS (you're currently taking)

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ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin
Codeine
Epinephrine
Erythromycin
Latex (balloon, gloves, etc.)
Local Anesthetic
Nitrous Ocide
Penicillin
Sulfa

Are you aware of being allergic to any other medications or substances?
If Yes, please list: ______________________________

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Is there any other Medical or Dental information that you feel I should know about? ______________________________

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Family Physician ______________________________ Phone No. ______________________________

Signature ______________________________ Date ______________________________