Richard J. McCann, D.M.D., P.A.

31413 Winterplace Parkway, Suite 101
Salisbury, Maryland 21804

First Name_________________________MI_____Last____

Sex: M___ F___ Birthdate________________________________ SS#__________________________________

Mailing Address____

City___________________________ State________ Zip___________ Home phone_______________________

Name, Phone # of closest relative not living with you____

Patient Employed by_________________________________ Occupation________________________________

Business Phone__________________________________ Cell Phone____________________________________

Person Responsible for Account____________________________ Relationship to Patient____________

In Whose Name is Insurance Policy____________________ Date of Birth of Ins. Holder____________

SS# of Ins. Holder________________ Employed by_________________ Bus. Phone_____________________

Spouse Name_______________________________________ Spouse Bus.Phone____________________________

Primary Dental Insurance Co.______________________________________ Phone________________________

Address______________________________________ Policy No.________________ Group No.____________

Secondary Dental Insurance Co.________________________ Phone____________________________________

How were you referred to our office? ____

If there was a simple, inexpensive way to whiten your teeth, would you be interested? Y N

I (we) the undersigned authorize treatment by the doctor and supporting staff members.
I (we) understand there may be a minimum charge of $10.00 for broken appointments without 24 hours notice.
I (we) authorize assignment of insurance benefits where applicable. If payment has not been received from the insurance company within four (4) weeks from the date of service, I will accept full responsibility for payment within thirty (30) days of notification.
I (we) assume full responsibility for balance of charges not covered by insurance company and agree to pay my estimated portion of charges at the time services are rendered.
I (we) accept full responsibility for any legal or collection agency fees should my account become delinquent.
I (we) understand there will be a 1 1/2% finance charge added to my account if it becomes delinquent.
I (we) understand that patients under the age of 18 years old must be accompanied by a parent or legal guardian
Please enter your name exactly as you would sign it in the signature field below. This constitutes an electronic signature as allowed by law.

Patient's Signature____ Date________________

Parent's Signature____ Date________________

(Continued on next page)

Medical History

Name of Physician____ Phone_____________________________

Last Physical Exam______________________ Reason____

Are you under medical treatment now? __________ Reason____

Please list any medications or prescriptions you may be taking____

____

Have you ever had any of the following diseases or medical problems?

Abnormal Blood Pressure	Y	N	Organ Transplant(s)	Y	N
Hepatitis	Y	N	Radiation Treatment	Y	N
Tuberculosis	Y	N	Chemotherapy	Y	N
Diabetes	Y	N	Heart Condition	Y	N
Epilepsy/Seizures	Y	N	Heart Murmur	Y	N
Asthma	Y	N	Pacemaker	Y	N
Anemia	Y	N	Mitral Valve Prolapse	Y	N
Blood Transfusion	Y	N	Artificial Heart Valves	Y	N
Hemophilia/Abnormal Bleeding	Y	N	Artificial Bones/Joints	Y	N
HIV/AIDS	Y	N	Congenital Heart Defect	Y	N
			Rheumatic Fever	Y	N

Are you allergic or sensitive to any of the following drugs or materials?

Penicillin	Y	N	Erythromycin	Y	N
Sulfa Drugs	Y	N	Tetracycline	Y	N
Codeine	Y	N	Dental Anesthetics	Y	N
Aspirin	Y	N	Latex	Y	N

Other:____

Dental History

Last Dental Visit____________ Service(s) Rendered____

How often do you brush your teeth?_________________________ Floss?______________________________

Do your gums bleed?___________________ When?____

Are your teeth sensitive to Hot, Cold, Sweet, Pressure?_________ When?______________________________

Do you smoke?	Y	N
Do you experience frequent headaches or tired jaws?	Y	N
Are you pleased with the appearance of your teeth?	Y	N
Do you have removable full dentures or partial dentures?	Y	N
Have you ever been treated by a Periodontist (gum specialist)?	Y	N
Have you ever been treated by an Orthodontist (braces)?	Y	N
Was a panoramic or full mouth radiograph taken within the last three years?	Y	N