

# 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

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

**(Please turn over)**

## 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