

MCMINNVILLE DENTAL GROUP
Laura A. Marcoullier D.M.D., P.C.

PATIENT NAME _____ Preferred Name _____ Date _____

S.S.#(adult) _____ Home _____ Work _____ Cell _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ Sex M or F (circle one) Married or Single or Child (circle one)

Email for confirming appointments _____

Person Responsible for Account _____ Phone # _____

Emergency Contact Person _____ Phone# _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance _____ Phone# _____

Address _____ Group # _____

Name Of Insured/Subscriber _____ S.S.# _____ D.O.B. _____

Subscriber ID# _____ Employer/Group Name _____

Secondary Dental Insurance _____ Phone# _____

Address _____ Group # _____

Name of Insured _____ S.S.# _____ D.O.B. _____

Subscriber ID# _____ Employer/Group Name _____

HEALTH INFORMATION- Fill out following forms

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in prior to appointment. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services performed without previous financial arrangements, must be paid for at the time services are performed.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time of payment thereof. I further agree that a waiver of any breach of any time or any condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home, at work, via cell or email, to discuss matters related to myself or dependent.

I understand Dr. Marcoullier's cancellation policy; that I must give 48 hour notice for rescheduling a reserved appointment or there will be a \$50 per hour reserved fee charged to my account.

I have read the above conditions of treatment and payment and agree to their content.

_____ **Date** _____ **Relationship to Patient** _____
Signature of patient/legal guardian

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO		YES	NO
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to _____	<input type="checkbox"/>	<input type="checkbox"/>	28. autoimmune disease _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			(i.e. rheumatoid arthritis, lupus, scleroderma)		
<input type="checkbox"/> penicillin			29. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			30. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			31. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulfa			32. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			33. neurologic disorders (ADD/ADHD, prion disease) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			34. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)			35. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			36. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____			37. STI / STD / HPV _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	38. hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	39. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	40. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	41. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
7. orthopedic implant (joint replacement) _____	<input type="checkbox"/>	<input type="checkbox"/>	42. chemotherapy, immunosuppressive medication _____	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	43. emotional difficulties _____	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	44. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	45. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	46. alcohol / recreational drug use _____	<input type="checkbox"/>	<input type="checkbox"/>
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:		
13. emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	47. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>	48. aware of a change in your health in the last 24 hours		
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	(i.e. fever, chills, new cough, or diarrhea) _____	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	<input type="checkbox"/>	<input type="checkbox"/>	49. taking medication for weight management _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	50. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	51. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	52. experiencing frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	53. a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	54. considered a touchy / sensitive person _____	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	55. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes (HbA1c = _____) _____	<input type="checkbox"/>	<input type="checkbox"/>	56. taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>	57. currently pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>	58. prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>			

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____