Marks Family Dentistry

674 Merrimon Ave., Suite 230-A
Asheville NC, 28804
828-255-8447

Thank you for choosing us for your dental care! Please complete this form so that we may serve you better.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET

_____
CITY STATE ZIP

Phone: Home ( ) _____ Work ( ) _____ Cell ( ) _____

Sex: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Birth date _____ Age _____ Social Security # _____ Drivers License # _____

Email address: _____ ❑ I would like to receive correspondences via e-mail.

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Emergency Contact: Name _____ Phone ( ) _____

Dental Insurance

Primary Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Employer Address _____

_____

Insurance Co. _____ Insurance Co. Address _____

_____

Insurance Co. Phone # _____ Group # _____

Relationship to patient _____

Preferred payment method (please circle one):

Cash Check Visa MasterCard Financing

Insurance Authorization Statement

I hereby authorize payment directly to Marks & Marks, DDS, PA of my group insurance benefits for services rendered. I understand that the benefits explained to me are only estimates, and I am responsible for all costs for dental treatment not covered by my insurance. The information on this page is correct to the best of my knowledge.

Signature _____ Date _____

Responsible Party (if different than patient)

Name _____ Relationship to Patient _____

Social Security # _____ Date of Birth _____

Address _____
STREET

_____
CITY STATE ZIP

Telephone ( )_____

Email Address _____

Other Information

How did you hear about us? _____

What is the reason for today's visit? _____

Do your gums bleed while brushing or flossing?

_____

Are your teeth sensitive to hot, cold, or sweets?

_____

Do you have pain or popping while chewing? _____

Is there anything you would like to change regarding your teeth? _____

Why did you leave your last dentist? _____

What did you like *most* about your last dentist? _____

What did you like *least* about your last dentist? _____

If you would like your records transferred, please tell us the name and address of your previous dentist.

_____

Treatment Authorization Form

I authorize and give consent to Marks & Marks, DDS, PA to perform dental services agreed upon between doctor and patient (and/ or parent or guardian) to be necessary or advisable including the use of local anesthesia and other medications as indicated.

Payment for all treatment and services rendered are my responsibility. I understand payment is due the same day services are rendered.

_____ _____
PATIENT'S SIGNATURE DATE

If patient is under 18 years of age or requires a guardian:

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Who is your primary medical doctor? _____

Date and reason of last visit _____

Please circle yes or no. If yes, please explain:

Are you under a physician's care now? Yes No

_____

Have you ever been hospitalized or had a major operation? Yes No _____

Have you ever had a serious head or neck injury? Yes No _____

Are you taking any medications, pills, or drugs? Yes No *If yes, please list.* _____

_____

_____

Do you take, or have you taken, Phen-Fen or Redux? Yes No _____

Are you on a special diet? Yes No _____

Do you use tobacco? Yes No What type? _____ How much? _____ How often? _____

Do you use controlled substances? Yes No _____

Do you use alcohol? Yes No How much? _____ How often? _____

Are you allergic to any of the following? If yes, please check and explain reaction.

- ❑ Aspirin
- ❑ Penicillin
- ❑ Codeine
- ❑ Acrylic
- ❑ Metal
- ❑ Latex
- ❑ Local Anesthetics
- ❑ Benzodiazepines
- ❑ Cephalosporin
- ❑ Tetracycline
- ❑ No known allergies

Please list any other allergies to medications: _____

Have you ever experienced an episode of abnormal bleeding? Yes No _____

Are you currently taking any blood thinning medications? (ie. Coumadin, Warfarin, Plavix, Aspirin) Yes No _____

Are you currently taking, or have you taken, steroids in the past two years? Yes No _____

Are you currently taking any bisphosphonate medications for osteoporosis? (ie. Actonel, Boniva, Fosamax, Didronel, Risedronate, IV therapy…) Yes No Please list name and dose:_____

Have you had a joint replacement surgery in the past two years? Yes No _____

Have you had or do you have an eating disorder? Yes No _____

Have you had or do you have Acid Reflux or GERD (Gastroesophageal Reflux Disease)? Yes No _____

Female Patients:

Pregnant or trying to get pregnant? Yes No

If yes, when is your due date? _____

Taking oral contraceptives? Yes No

Nursing? Yes No

Do you have, or have you had, any of the following?

AIDS/HIV Positive	O Yes O No	Cortisone Medication	O Yes O No	Hemophilia	O Yes O No	Renal Dialysis	O Yes O No
Alzheimer's Disease	O Yes O No	Diabetes	O Yes O No	Hepatitis A	O Yes O No	Rheumatic Fever	O Yes O No
Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No	Hepatitis B or C	O Yes O No	Rheumatism	O Yes O No
Anemia	O Yes O No	Easily Winded	O Yes O No	Herpes	O Yes O No	Scarlet Fever	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	High Blood Pressure	O Yes O No	Shingles	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	Hives or Rash	O Yes O No	Sickle Cell Disease	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No	Hypoglycemia	O Yes O No	Sinus Trouble	O Yes O No
Artificial Joint	O Yes O No	Excessive Thirst	O Yes O No	Irregular Heartbeat	O Yes O No	Spina Bifida	O Yes O No
Asthma	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Kidney Problems	O Yes O No	Stomach Intestinal Disease	O Yes O No
Blood Disease	O Yes O No	Frequent Cough	O Yes O No	Leukemia	O Yes O No	Stroke	O Yes O No
Blood Transfusion	O Yes O No	Frequent Diarrhea	O Yes O No	Liver Disease	O Yes O No	Swelling of Limbs	O Yes O No
Breathing Problems	O Yes O No	Frequent Headaches	O Yes O No	Low Blood Pressure	O Yes O No	Thyroid Disease	O Yes O No
Bruise Easily	O Yes O No	Genital Herpes	O Yes O No	Lung Disease	O Yes O No	Tonsillitis	O Yes O No
Cancer	O Yes O No	Glaucoma	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tuberculosis	O Yes O No
Chemotherapy	O Yes O No	Hay Fever	O Yes O No	Pain in Jaw Joints	O Yes O No	Tumors or Growths	O Yes O No
Chest Pains	O Yes O No	Heart Attack/Failure	O Yes O No	Parathyroid Disease	O Yes O No	Ulcers	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Murmur	O Yes O No	Psychiatric Care	O Yes O No	Venereal Disease	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Pace Maker	O Yes O No	Radiation Treatments	O Yes O No	Yellow Jaundice	O Yes O No
Convulsions	O Yes O No	Heart Trouble/Disease	O Yes O No	Recent Weight Loss	O Yes O No		O Yes O No

Please list any serious illness you have that is not listed above? _____

Comments:

_____

_____

_____

_____

_____

_____

To the best of my knowledge, the questions on this from have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent, or Guardian_____Date_____