MyDentist®

BIOLOGICAL DENTISTRY BY DR. MICHAEL MARGOLIS & ASSOCIATES
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Welcome

Thank you for selecting My Dentist. To help us meet all your health care needs please fill out this form completely in ink. If you have any questions or need assistance, please ask us, we'll be happy to help.

Patient Information (CONFIDENTIAL)

Email Address: ______________

Name: ______________ Date: ______________

Soc Sec # ______________ Birth date: __________ Home Phone: ______________ Cell Phone: ______________

Address: ______________ City: ______________ State: ____ Zip: __________

Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

If Student, Name of School/College: ______________ City: ______________ State: ____

Full Time Part Time

Patient's or Parent's Employer: ______________ Work Phone: ______________

Business Address: ______________ City: ______________ State: ____ Zip: ______

Spouse or Guardian's Name: ______________ Employer: ______________ Work Phone: ______________

Whom May We Thank For Referring You? ______________

Person to Contact in Case of Emergency: ______________

Responsible Party

Name of Person Responsible for this Acct: ______________ Relationship to Patient: ________

Address: ______________ Home Phone: ______________ Driver's License #: ______________

Birth date: ______________ Financial Institution: ______________

Employer: ______________ Work Phone: ______________ SS#: ______________

Is this Person Currently a Patient in our Office? ☐YES ☐NO

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full is required at each appointment.

☐Cash ☐Personal Check Credit Card: ☐Visa ☐MasterCard ☐Other (Please discuss with office staff)

All Services Provided By An Arizona Licensed General Dentist

Insurance Information

Name of Insured: ______________________________ Relationship to Patient: ______________

Soc Sec # __________________ Birth date: ________________ Date Employed: ______________

Name of Employer: ______________________ Union or Local #: _________ Work Phone: __________

Employer Address: ________________________ City: ______________ State: _____ Zip: _______

Insurance Company: ___________________________ Group #: _________ Policy/ID#: __________

Ins. Co Address: ________________________ City: ______________ State: _____ Zip: _______

Deductible Amount: $_________ How much have you used? $_________ Max Annual Benefit: $__________

Do You Have Any Additional Insurance? **Yes No If Yes, Complete the Following**

Name of Insured: ______________________________ Relationship to Patient: ______________

Soc Sec # __________________ Birth date: ________________ Date Employed: ______________

Name of Employer: ______________________ Union or Local #: _________ Work Phone: __________

Employer Address: ________________________ City: ______________ State: _____ Zip: _______

Insurance Company: ___________________________ Group #: _________ Policy/ID#: __________

Ins. Co Address: ________________________ City: ______________ State: _____ Zip: _______

Deductible Amount: $_________ How much have you used? $_________ Max Annual Benefit: $__________

Patient Medical History

Physician: __________________________ Office Phone: ______________ Date of Last Exam: _____

Are you under medical treatment now? ☐YES ☐NO

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? ☐YES ☐NO

If yes, please explain: ____

____

Are you taking any medication(s) including non prescription medicine? ☐YES ☐NO

If yes, please explain: ____

____

Sex: ☐ MALE ☐ FEMALE

If female please answer the following:

Are you taking Birth Control Pills? ☐YES ☐NO

Are you Pregnant? ☐YES ☐NO If Yes, # of weeks: ______

Are you nursing? ☐YES ☐NO

For Office Use Only

BP [/] Heart Rate: [ ]

Please answer the following:

Do you smoke or use tobacco? ☐YES ☐NO

Height: __________

Weight: __________

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

	YES	NO
High Blood Pressure	☐	☐
Pace Maker	☐	☐
Stroke	☐	☐
Heart Trouble	☐	☐
Low Blood Pressure	☐	☐
Difficulty Breathing	☐	☐
Allergies	☐	☐
Emphysema	☐	☐
Hemophilia	☐	☐
Abnormal Bleeding	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Kidney Problems	☐	☐
Thyroid Problems	☐	☐
Cancer - Chemotherapy	☐	☐
Glaucoma	☐	☐
HIV+ / AIDS	☐	☐
Chronic Fatigue Syndrome	☐	☐
Fibromyalgia	☐	☐
Heart Surgery	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Angina Pectoris	☐	☐
Congenitial Heart Defect	☐	☐
Artificial Heart Valve	☐	☐
Mitral Valve Prolapse	☐	☐
Rheumatic Fever	☐	☐
Tuberculosis	☐	☐
Asthma	☐	☐
Diabetes	☐	☐

	YES	NO
Hepatitis A	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
Joint Replacement	☐	☐
Liver Disease	☐	☐
Ulcers	☐	☐
Radiation Therapy	☐	☐
Epilepsy	☐	☐
Venereal Disease	☐	☐
Fainting Spells	☐	☐
Seizures	☐	☐
Blood Transfusion	☐	☐
Frequent Headaches	☐	☐
Pain in Jaw Joints	☐	☐
Psychiatric Problems	☐	☐
Shingles	☐	☐
Sinus Problems	☐	☐
Alcohol Abuse	☐	☐
Drug Abuse	☐	☐
Jaundice	☐	☐

ALLERGIES		
Aspirin	☐	☐
Codeine	☐	☐
Dental Anesthetics	☐	☐
Erythromycin	☐	☐
Jewelry	☐	☐
Latex	☐	☐
Metals	☐	☐
Penicillin	☐	☐
Tetracycline	☐	☐

Other: ______________________

Patient Dental History

	YES	NO
Do your gums bleed while brushing and flossing?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
Do you feel pain to any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you ever experienced any of the following problems in your jaw?		
Clicking?	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing?	☐	☐
Difficulty in chewing?	☐	☐
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth frequently?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you ever had any difficult extractions in the past?	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐
Have you had any orthodontic treatment?	☐	☐
Do you wear dentures or partials?	☐	☐
if yes, date of placement ______________		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
Do you like to smile?	☐	☐

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish the persons responsible to know that all professional services rendered are charged directly to them and that they are responsible for payment of fees. We will prepare the necessary forms or reports to help the persons responsible obtain benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

PAYMENT FOR SERVICES: Payment for services is due at the time the service is rendered. In the event payment is not made when the services are rendered and a monthly statement is sent, payment will be expected within 10 days after the statement is received. All appliances, dentures, crowns, etc., must be paid for at the time they are delivered, or in compliance with special payment arrangements. With all accounts wherein payment is not received within 10 days of the date that the statement is received, a finance charge of 1.5% per month may be charged on the outstanding balance. In the event it becomes necessary to place this account for collections, the undersigned agrees to pay in addition to any amounts due and owing reasonable costs of collection. In the event it becomes necessary to file a legal action or proceeding to collect the account, the undersigned agrees to pay in addition to any amounts due and owing reasonable attorney's fees and court costs. By signing below you indicate that you have read all of the foregoing and understand the same, and agree that Dental Services are being rendered in accordance with the foregoing.

I UNDERSTAND THERE WILL BE A $25.00 CHARGE PER 1/2 HOUR APPOINTMENT MISSED ($50.00 PER HOUR) WITHOUT A 24 HOUR NOTICE. NO EXCEPTIONS.

______________________________ SIGNATURE ____________ DATE