THOMAS F. McCOY III, D.D.S.

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Metairie, Louisiana 70006
889-1209

We would like to take this opportunity to welcome you to the practice and thank you for your expression of confidence in us.

Please take a few minutes to read and complete this brief form. It will help us better serve you in the future. Thank you.

Date____________________

Patient Health History

(For office use only)
Account ID__________________

Patient Information

Mr/Mrs/Miss/Ms ______________________________

SSN ______________________________

Birthdate ____________________ Male / Female

Address ______________________________

City __________________ State_____ Zip________

Phone H. ______________ O.______________

Occupation ______________________________

Referred by ______________________________

Spouse ______________________________

SSN ______________________________

Person Responsible for the Account

Name ______________________________

SSN ______________________________

Address ______________________________

City __________________ State_____ Zip________

Phone H. ______________ O.______________

Occupation ______________________________

Primary Dental Insurance Information

Name of Insured______________________________

Birthdate of Insured ______________________________

Employer ______________________________

Office Phone______________________________

Insurance Co. ______________________________

Ins. Address ______________________________

City __________________ State_____ Zip________

Group No. ______________________________

Coverage:

☐ Family ☐ Self and Dependents ☐ Self Only

Secondary Dental Insurance Information

Name of Insured______________________________

Birthdate of Insured ______________________________

Employer ______________________________

Office Phone______________________________

Insurance Co. ______________________________

Ins. Address ______________________________

City __________________ State_____ Zip________

Group No. ______________________________

Coverage:

☐ Family ☐ Self and Dependents ☐ Self Only

(Please Turn This Sheet Over)

Medical History Information

Please check yes or no in all boxes that apply to the patient.

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Anemia/Blood Disease	☐	☐	Fainting/Nervous	☐	☐	Mitral Valve Prolapse	☐	☐	Thyroid
☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐	Neck/Head Pain	☐	☐	Taking Aspirin?
☐	☐	Asthma/Hay Fever	☐	☐	Heart Trouble	☐	☐	Pregnant (Due_______)	☐	☐	Taking Coumadin?
☐	☐	Blood Pressure/High	☐	☐	Pace Maker	☐	☐	Rheu Fever/Murmur			*Allergic to:*
☐	☐	Blood Pressure/Low	☐	☐	Hepatitis/Liver Disease	☐	☐	Stroke	Yes	No	
☐	☐	Cancer/Tx/X-Ray	☐	☐	Herpes Virus	☐	☐	TB/Lung Disease	☐	☐	Aspirin
☐	☐	Diabetes	☐	☐	HIV Positive/AIDS	☐	☐	TMJ/Clicking Joint	☐	☐	Codeine
☐	☐	Epilepsy/Seizures	☐	☐	Joint Replacement	☐	☐	Venereal Disease	☐	☐	Local Anesthesia
☐	☐	Hemophilia	☐	☐	Migraine Headaches	☐	☐	Prosthetic Heart Valve	☐	☐	Penicillin
☐	☐	Taking birth control pills?	☐	☐	Skin reactions to jewelry?	☐	☐	Taken the drug Fen-Phen?	☐	☐	Sulphur

☐ ☐ Cardiovascular disease (heart attack, angina, coronary insufficiency, coronary occlusion, arteriosclerosis)

My Medical Physician is ______________________________

Taking Medications ☐ Yes ☐ No If yes, ______________________________

Allergic to Medications ☐ Yes ☐ No If yes, ______________________________

Prior Unpleasant Dental Treatment______________________________

General Health Comments ______________________________

Medical history updated on______________________________

What is your main concern with your teeth and mouth?______________________________

OFFICE POLICY

- We ask that payment be made in full at the time of your visit. We accept cash, personal checks, Visa, MasterCard & Discover.
- Insurance coverage is a contract between you and your insurance company. The fees for services is the patient's responsibility.
- Arrangements can be made for professional fees covered by insurance, however, co-insurance payments are payable at the time of service. Fees for initial visits are payable in full regardless of insurance coverage.
- As a courtesy to our patients, we gladly file your insurance claims at no charge. We cannot, however, accept responsibility for delayed or disallowed payments on the part of the insurance carrier. If your insurance has not paid within 30 days we ask that you contact your insurance company and ask them why payment has been delayed. If they have still failed to make payment within 45 days we require that you pay the outstanding balance, and seek personal reimbursement from your insurance carrier.
- We do realize that insurance is often complicated, so please feel free to call the office for assistance. Our Accounts Manager stands ready to help you!

The above information is true and complete to the best of my knowledge. I understand and agree to these terms.

Patient Signature: ______________________________ Date:__________________