Chart # ____________________
FOR OFFICE USE ONLY

Jeff Mercando DMD
FAMILY & COSMETIC DENTISTRY

## Patient Information

| Patient Name | | | Sex |
|---|---|---|---|
| Address (City, State, ZIP) | | Marital Status (Married, Single, Child, Other) | |
| Social Security Number | | Birth Date | |
| E-mail Address | | | |
| Home Phone | Work Phone | Cell Phone | Best Time to Call |
| Emergency Contact Name | | Emergency Contact Phone Number | |

## Health Information

| Date of Last Visit | Reason for This Visit |
|---|---|
| | |

**Have you ever had any of the following? Please check all that apply:**

- ❑ Acid Reflux
- ❑ AIDS/HIV
- ❑ Allergies ____________________
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Heart Valve
  Date: ______________
- ❑ Artificial Joint
  Date: ______________
- ❑ Asthma
- ❑ Autism/Asperger
- ❑ Bleeding Disorder (Anemia/Hemophilia)
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Depression/Anxiety
- ❑ Diabetes
- ❑ Dizziness
- ❑ Eating Disorder
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Fainting/Dizzy
- ❑ Frequent Cold Sores
- ❑ Glaucoma
- ❑ Growths
- ❑ Hay Fever
- ❑ Head Injuries
- ❑ Hearing Problems
- ❑ Hearth Attack
  Date: ______________
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Jaundice
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease (COPD)
- ❑ Mental Disorders
- ❑ Nervous Disorders
- ❑ Pacemaker
- ❑ Pregnancy
  Due Date: ______________
- ❑ Radiation/Chemo
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Seizures
- ❑ Sinus Problems
- ❑ Stomach Problems
- ❑ Stroke
  Date: ______________
- ❑ Thyroid Condition
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Codeine Allergy
- ❑ Penicillin Allergy
- ❑ OTHER: ____________________

**Are you currently taking any medications?**

| DRUG NAME | DOSAGE | REASON |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

(Health Information Continued on Next Page)

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## Health Information (continued)

Have you ever taken medications(such as bisphosphonates) that affect bone or to prevent bone disease?
(ie. Fosamax, Zometa, Actonel, Aredia) ❑ Yes ❑ No

If applicable, are you required to take a premedication prior to your dental appointment (ie. joint replacement, history of infective endocarditis)?
❑ Yes ❑ No
If Yes, please explain:

Do you currently (or have you ever used) tobacco products? ❑ No ❑ Yes, currently ❑ Yes, but no longer
❑ Cigarette ❑ Cigar ❑ Snuff ❑ Dip ❑ Vape ❑ Other
How frequently?:

Have you ever had any complications following dental treatment? ❑ Yes ❑ No
If Yes, please explain:

Have you been admitted to a hospital or needed emergency care during the past 2 years? ❑ Yes ❑ No
If Yes, please explain:

Are you currently under the care of a physician? ❑ Yes ❑ No
If Yes, please explain:

| Name of Physician | Physician's Phone |
|---|---|
| | |

## Notes

Any other information that you would like to add?

## Signature

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes to my health, I will inform the doctors at the next appointment without fail.

Relationship to patient ❑ Self ❑ Parent ❑ Guardian ❑ Other ______________________

| Signature of patient, parent or guardian | Date |
|---|---|
| | |

## Referral Information

Whom may we thank for referring you to our practice?

❑ Another Patient, Friend ❑ Another Patient, Relative ❑ Dental Office ❑ Online ❑ Newspaper ❑ School ❑ Work

Name of person or office referring you to our practice:

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## Spouse or Responsible Party Information

The following is for ❑ The Patient's Spouse ❑ The Person Responsible for Payment

| Name | | Birth Date | Sex |
|---|---|---|---|
| Address (City, State, ZIP) | | Marital Status (Married, Single, Child, Other) | |
| Social Security Number | E-mail Address | | |
| Home Phone | Work Phone | Cell Phone | Best Time to Call |

## Employee Information

The following is for ❑ The Patient ❑ The Person Responsible for Payment

| Employer Name | Occupation |
|---|---|
| Address (City, State, ZIP) | |

## Insurance Information

| **PRIMARY** \| Name of Insured | Is Insured a Patient?<br>❑ Yes ❑ No | Patient's Relationship to Insured<br>❑ Self ❑ Spouse ❑ Child ❑ Other |
|---|---|---|
| Insured's Birth Date | ID # | Group # |
| Insured's Address (City, State, ZIP) | | |
| Insured's Employer Name | Insured's Employer Address (City, State, ZIP) | |
| Insurance Plan Name | Insurance Plan Address (City, State, ZIP) | |

| **SECONDARY** \| Name of Insured | Is Insured a Patient?<br>❑ Yes ❑ No | Patient's Relationship to Insured<br>❑ Self ❑ Spouse ❑ Child ❑ Other |
|---|---|---|
| Insured's Birth Date | ID # | Group # |
| Insured's Address (City, State, ZIP) | | |
| Insured's Employer Name | Insured's Employer Address (City, State, ZIP) | |
| Insurance Plan Name | Insurance Plan Address (City, State, ZIP) | |

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. 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, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However the dental office can not render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient's examination.

In consideration for the professional services rendered to me, or at my request, but the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his 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 billed unless objected to by me in writing within the time for payment thereof. I further agree that a waiver of any breach of any time or 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 or at my work to discuss matters related to this form.

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

| Signature of Patient, Parent or Guardian | Date | Relationship to Patient |
|---|---|---|
| Signature of Guarantor of Payment/Responsible Party | Date | Relationship to Patient |

Jeff Mercando DMD
FAMILY & COSMETIC DENTISTRY

# Jeffrey D. Mercando, DMD
# Privacy Authorization

JANUARY 2026

Dear Patient:

HIPAA (The Health Insurance Portability and Accountability Act) requires our office to obtain your permission to use or disclose your dental information

As you know, we create paper and electronic dental records about your health and the service we provide to you. We understand that your dental/medical information is personal to you and we are committed to protecting that information for you.

Your signature on this consent gives our office your permission to perform any tasks including but not limited to:

- Bill your insurance Company
- Call in prescriptions to your pharmacy
- Contact you by phone to confirm appointments
- Relay information to you over the phone or as a message left on a voicemail.
- Speak with any professional provider regarding your dental condition if warranted for coordination of care
- Communicate with the following family member(s). Please provide name and relationship

| Name of Family Member | Relationship to Patient |
|---|---|
| Name of Family Member | Relationship to Patient |

I acknowledge that I was presented with a complete Notice of Privacy Practices for this office and I have read the above disclosure information guidelines and agree to them without restrictions

| Signature | Date |
|---|---|
| | |

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# Insurance Authorization Signature on File

**JEFFREY D. MERCANDO, D.M.D., P.C.**
1032 NORTH EASTON ROAD, SUITE B
DOYLESTOWN, PA 18902
(215) 340-9876

I hereby authorize my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to me and my dependents.

I also authorize payment of healthcare benefits otherwise payable to me, directly to my doctor listed above. I agree to be held responsible for all charges and services not paid by my insurance company.

| Signature of Patient or Insured | Today's Date |
|---|---|
| Witnessed by | Expiration Date |

The Signature on File (SOF) is valid from this date and expires in one year. A photocopy of this authorization may act as an original.