

Chart # _____
FOR OFFICE USE ONLY

Patient Information

Patient Name	Sex	Birth Date
Address (City, State, ZIP)		Marital Status (Married, Single, Child, Other)
E-mail Address		
Home Phone	Cell Phone	
Emergency Contact Name	Emergency Contact Phone Number	

Health Information

Date of Last Visit	Reason for This Visit		
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Have you ever had any of the following? Please check all that apply:

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

Are you currently taking any medications?

DRUG NAME	DOSAGE	REASON

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

Health Information

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:

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? ☐ Yes ☐ No	Patient's Relationship to Insured ☐ 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? ☐ Yes ☐ No	Patient's Relationship to Insured ☐ 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

Jeffrey D. Mercado, 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.