PATIENT INFORMATION

Name_____Male___Female____ Birthdate____/____/____

Street address_____Home phone_____

City, State, Zip _____Cell phone_____

Occupation_____Employer_____Work phone_____

Spouse's name_____ Birthdate____/____/____

Spouse's employer_____ Work phone_____

Name of emergency contact not in your household_____

Relationship_____ Home phone_____ Work phone_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT?

Name_____ Birthdate____/____/____

Street address_____City,State, Zip_____

Relationship to patient_____ Home phone_____ Work phone_____

DENTAL INSURANCE INFORMATION

Subscriber name_____ Birthdate____/____/____

Relationship to patient_____ Subscriber ID#_____

Insurance company_____ Group#_____

Secondary insurance company_____ Subscriber name_____

Relationship to patient_____ Subscriber ID#_____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I assign directly to Maharry Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I also understand that I am financially responsible for all charges whether or not covered or paid by insurance. I hereby authorize Maharry Family Dentistry to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of parent or guardian Date

DENTAL HISTORY

Reason for today's visit_____

_____

Former dentist_____

City/State_____

Date of last dental x-rays_____

Please check any of the following you are experiencing:

_____Bad breath
_____Loose teeth or broken fillings
_____Jaw pain or tiredness
_____Bleeding gums
_____Clicking or popping jaw
_____Grinding teeth
_____Gums swollen / tender
_____Orthodontic treatment
_____Periodontic treatment
_____Sensitivity to pressure/chewing
_____Sensitivity to cold
_____Sensitivity to sweets
_____Tobacco use

Please list all medications you are prescribed:

_____
_____
_____
_____
_____
_____
_____
_____

MEDICAL HISTORY

Date of last medical examination_____

Primary care physician_____

Physician's phone_____

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

Yes____No____Treatment for osteoporosis (Fosamax, Boniva, Zometa, Didronel, Skelid, Aredia, Bonefos)
Yes____No____Artificial heart valve
Yes____No____History of bacterial endocarditis
Yes____No____Congenital heart disease
Yes____No____Surgical repair of congenital heart defect, date_____
Yes____No____Organ transplant,details_____
Yes____No____Prosthetic joint replacement, date & joint type_____
_____
Yes____No____Artificial implant or graft of any kind not listed_____
_____
Yes____No____Immunosuppressive condition (circle all that apply) steroid therapy, radiation or cancer therapy, lupus, rheumatoid arthritis, organ transplant, other_____
Yes____No____Physician requests antibiotic coverage for dental treatment, reason_____
Yes____No____AIDS, HIV
Yes____No____Epilepsy, seizure disorder
Yes____No____Hepatitis
Yes____No____Cardiac bypass surgery, details_____
_____
Yes____No____Coumadin(warfarin) or other blood thinner therapy
Yes____No____Drug / alcohol abuse
Yes____No____Abnormal blood pressure: High or Low
Yes____No____Difficulty breathing, details_____
Yes____No____Diabetes

Please list any other medical conditions you have that may affect your dental treatment_____

Yes____No____ *WOMEN*: Are you pregnant or is there a chance you may be pregnant?

Drug Allergies:

_____Local anesthetic
_____Codeine, hydrocodone
_____Others, list_____
_____Penicillin, amoxicillin antibiotics
_____Latex or rubber
_____Cephalosporin antibiotics

I acknowledge that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Signature Date