

Welcome

Thank you for selecting our dental health team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us. We will be happy to help.

Patient Information (Confidential)

Name: _____ SS# _____ DOB _____
 Gender: Male Female Check one: Single Married Widowed Separated Divorced
 Address _____
 City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Business Phone _____
 Email _____
 Emergency Contact: _____ Phone: _____
 How did you hear of our office? _____

If you could, what would you change about your smile?
 Straighter Teeth Whiter Teeth Other _____

Responsible Party

Name of person responsible for this account _____ Gender: M F
 Relationship to Patient _____

Insurance Information

Subscriber Name _____
 Relationship to Patient _____ Subscriber DOB _____ Plan Type: Family Ind.
 ID Number _____ Group Number _____
 Subscriber's Employer _____ Work Phone _____
 Insurance Company _____ Phone _____
 Insurance Company Address _____

Mulroy Family Dental as a courtesy will file insurance claims to the insurance company. The insured or patient authorizes the insurance company to pay the provider directly. All deductibles, copays, and denied claims will be the responsibility of the patient. Please feel free to contact our office with any questions.

Patient Medical History

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| <p>1. Are you under medical treatment now? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>2. Have you been hospitalized for any surgical operation or serious illness within the last 5 yrs? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>3. Are you taking any medications including non-prescription medicine? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>4. If yes, list: _____</p> <p>5. Do you use tobacco? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>6. Do you use controlled substances? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>7. Are you wearing contact lenses? <input type="checkbox"/> Y <input type="checkbox"/> N</p> | <p>8. Are you allergic or have you had any reactions to the following?
 Local anesthetics <input type="checkbox"/> Y <input type="checkbox"/> N
 Penicillin or other antibiotics <input type="checkbox"/> Y <input type="checkbox"/> N
 Sulfa Drugs <input type="checkbox"/> Y <input type="checkbox"/> N Barbituates <input type="checkbox"/> Y <input type="checkbox"/> N
 Sedatives <input type="checkbox"/> Y <input type="checkbox"/> N Iodine <input type="checkbox"/> Y <input type="checkbox"/> N
 Aspirin <input type="checkbox"/> Y <input type="checkbox"/> N Any metals <input type="checkbox"/> Y <input type="checkbox"/> N
 Latex Rubber <input type="checkbox"/> Y <input type="checkbox"/> N Other _____</p> <p>9. Are you pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N Are you nursing? <input type="checkbox"/> Y <input type="checkbox"/> N
 Are you taking oral contraceptives? <input type="checkbox"/> Y <input type="checkbox"/> N</p> |
|--|---|
10. Do you have or have you had any of the following?
- | | | |
|---|--|--|
| <p>High Blood Pressure <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Heart Attack <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Rheumatic Fever..... <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Swollen Ankles <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Fainting/Seizures <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Asthma/Hayfever <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Low blood pressure <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Epilepsy/convulsions <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Leukemia <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Kidney diseases <input type="checkbox"/> Y <input type="checkbox"/> N</p> | <p>AIDS or HIV <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Thyroid problems <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Heart disease <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Cardiac pacemaker <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Heart murmur <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Angina <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Frequently tired <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Anemia <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Emphysema <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Cancer <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Arthritis <input type="checkbox"/> Y <input type="checkbox"/> N</p> | <p>Joint replacement <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Hepatitis/Jaundice <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Sexually trans. disease <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Stomach troubles/ulcers ... <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Chest pains <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Easily bruised/wounded ... <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Stroke <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Hay Fever/ Allergies <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Tuberculosis <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Radiation therapy <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Glaucoma <input type="checkbox"/> Y <input type="checkbox"/> N</p> |
|---|--|--|

Liver disease Y N
 Heart trouble Y N
 Respiratory problems Y N
 Mitral Valve Prolapse Y N
 Bruise or Bleed Easily/
 Hemophiliac..... Y N
 Marked Weight Change... Y N
 Special Diet..... Y N

Dizziness/Fainting..... Y N
 Tire Easily/Weakness..... Y N
 Sinus Problems..... Y N
 Headaches..... Y N
 Difficulty Breathing while lying
 down..... Y N
 Artificial Heart Valve..... Y N
 Congenital Heart Disease. Y N

Shortness of Breath..... Y N
 Chest pain or discomfort.... Y N
 Tumors/Cancer..... Y N
 Autoimmune Disease..... Y N
 Radiation therapy..... Y N

Patient Dental History

Previous Dentist _____ City _____ Phone _____
 Date of Last exam _____ Date of Last X-Rays _____

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|--|---|
| <p>1. Do your gums bleed while brushing/ flossing?<input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>2. Are your teeth sensitive to hot or cold?.....<input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>3. Are your teeth sensitive to sweet or sour?<input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>4. Do you feel pain in any of your teeth?<input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>5. Do you have sores in or near your mouth?<input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>6. Have you had any head, neck, or jaw injuries? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>7. Have you ever experienced any of the following problems in your jaw?
 Clicking? <input type="checkbox"/> Y <input type="checkbox"/> N
 Pain? <input type="checkbox"/> Y <input type="checkbox"/> N
 Difficulty in chewing? <input type="checkbox"/> Y <input type="checkbox"/> N
 Difficulty in opening/closing? <input type="checkbox"/> Y <input type="checkbox"/> N</p> | <p>8. Do you have frequent headaches?<input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>9. Do you clench or grind your teeth?<input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>10. Do you bite your lips or cheeks frequently?<input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>11. Have you had any difficult extractions?<input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>12. Have you had any prolonged bleeding following extractions?.....<input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>13. Have you had any orthodontic treatment?..... <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>14. Do you wear dentures or partials?<input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>15. Have you ever been treated for periodontal disease or gum disease?.....<input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>16. Do you like your smile?.....<input type="checkbox"/> Y <input type="checkbox"/> N</p> |
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Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents.

I have read and agree with Mulroy Family Dental's HIPAA (Notice of Privacy Practices) statement.

Signature of Patient (or Parent if Minor) _____ Date _____

Doctor's Comments

Signature _____ Date _____