Welcome

MULROY
Family Dental

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 _____
We are able to email appointment reminders and other office communication. To take advantage of this service, please provide your 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

1. Are you under medical treatment now? □ Y □ N
2. Have you been hospitalized for any surgical operation or serious illness within the last 5 yrs? □Y □N
3. Are you taking any medications including non-prescription medicine? □ Y □ N
4. If yes, list:_____
5. Do you use tobacco? □ Y □ N
6. Do you use controlled substances? □ Y □ N
7. Are you wearing contact lenses? □ Y □ N
8. Do you need antibiotics before a dental visit? □ Y □ N
9. Are you allergic or have you had any reactions to the following?
   Local anesthetics □ Y □ N
   Penicillin or other antibiotics □ Y □ N
   Sulfa Drugs □ Y □ N Barbituates □ Y □ N
   Sedatives □ Y □ N Iodine □ Y □ N
   Aspirin □ Y □ N Any metals □ Y □ N
   Latex Rubber □ Y □ N Other_____
10. Are you pregnant? □Y □N Are you nursing? □Y □N
    Are you taking oral contraceptives? □ Y □ N

11. Do you have or have you had any of the following?

High Blood Pressure ..... □ Y □ N	Diabetes .....□ Y □ N	Anemia ..... □ Y □ N
Heart Attack .....□ Y □ N	Kidney diseases .....□ Y □ N	Emphysema .....□ Y □ N
Rheumatic Fever..... □ Y □ N	AIDS or HIV .....□ Y □ N	Cancer .....□ Y □ N
Swollen Ankles .....□ Y □ N	Thyroid problems .....□ Y □ N	Arthritis .....□ Y □ N
Fainting/Seizures .....□ Y □ N	Heart disease .....□ Y □ N	Joint replacement .....□ Y □ N
Asthma/Hayfever .....□ Y □ N	Cardiac pacemaker .....□ Y □ N	Hepatitis/Jaundice .....□ Y □ N
Low blood pressure .....□ Y □ N	Heart murmur .....□ Y □ N	Sexually trans. disease .....□ Y □ N
Epilepsy/convulsions .....□ Y □ N	Angina .....□ Y □ N	Stomach troubles/ulcers ...□ Y □ N
Leukemia .....□ Y □ N	Frequently tired .....□ Y □ N	Chest pains .....□ Y □ N

Easily bruised/wounded …□ Y □ N
Stroke ……..……□ Y □ N
Hay Fever/ Allergies ……..□ Y □ N
Tuberculosis ……..……□ Y □ N
Radiation therapy ……...□ Y □ N
Glaucoma ……□ Y □ N
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
History of Infective
Endocarditis……□ Y □ N
Other Heart Condition…….□ Y □ N
If yes, list:_____
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 _____

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

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

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Signature_____ Date_____