maury family dental

Patient Information

Date :_____

Patient Name: _____ If Child: Parent's Name :_____
Last First MI (Preferred Name)

Date of Birth _____ Gender: ☐ Male ☐ Female

Phone (Home): _____ (Cell): _____ (Work): _____

E-mail Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Whom may we thank for this referral: _____

Employer: _____ Occupation: _____

Who is responsible for this account: _____

Emergency contact: _____ Phone #_____

Dental Information

When was your last dental visit? _____ What was done at that time? _____

Are you aware of a problem? _____

When was the last time your teeth were cleaned? _____

Have you ever had any problems or complications with previous dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

Do you clench or grind your teeth? ☐ Yes ☐ No Does your jaw click or pop? ☐ Yes ☐ No

Have you experienced any pain or soreness in the muscles of your face or around your ear? ☐ Yes ☐ No

Do you have frequent headaches, neckaches, or shoulder aches? ☐ Yes ☐ No

Are any of your teeth sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Pressure

Do your gums bleed or hurt? ☐ Yes ☐ No Do you experience dry mouth? ☐ Yes ☐ No

How often do you brush your teeth? _____ When? _____

Do you use dental floss? ☐ Yes ☐ No How often?_____

Are you unhappy with the appearance of your teeth? ☐ Yes ☐ No

How do you feel about your teeth in general? _____

Have you ever had gum treatment or surgery? _____

Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?
_____

Health Information

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

☐ Allergies
Please list: _____
☐ Latex or Metals Allergy
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Anemia/ leukemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Bisphosphonates for bone tumors or osteoporosis
☐ Blood Thinner/ Coumadin
☐ Cancer/ Chemotherapy
☐ Diabetes/ Type _____
☐ Dizziness/ Fainting
☐ Epilepsy/Seizures
☐ Excessive Bleeding
☐ High Blood Pressure
☐ HIV or AIDS positive
☐ Low Blood Pressure
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis/ Type_____
☐ Pacemaker, artificial heart valve, or mitral valve prolapse
☐ Kidney/ Liver/ Stomach Problems
☐ Psychiatric Treatment
☐ Radiation Treatment
☐ Rheumatic Fever
☐ Rheumatism
☐ Stroke
☐ Tuberculosis
☐ Ulcers
☐ Tobacco Use

Please list current prescriptions you are taking.

_____

Have you been admitted to a hospital or needed emergency care in the past two years? ☐ Yes ☐ No
If yes, please explain:

_____

Are you now under the care of a physician? ☐ Yes ☐ No Are you pregnant or suspect you may be? ☐ Yes ☐ No

Name of Physician: _____ Phone:_____

Do you have any disease, condition, or problem not listed? Is there anything else we should know about you or your health that we have not covered on this form? If so, please explain:

_____

Consent for Services

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.
_____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the above information provided.

_____ Date: _____ Relationship to patient: _____
Signature of patient, parent, or guardian