Mr.
Ms.
Mrs.
Dr.
Male/Female

WELCOME TO OUR OFFICE

Today's Date _____

Name _____ Date of Birth _____ S.S.# _____
Last First M.I. **Age** _____

Address _____ Marital Status _____

City _____ State _____ Zip _____ Home Phone _____

Place of Employment _____ Office Phone _____

Person responsible for payment of account _____ Cell Phone # _____

Full Name of Spouse/Parent _____ Spouse's Occupation _____

E-mail Address _____

Physician's Name _____ Physician's Phone _____

In Case of Emergency Notify _____ Phone _____

Who may we thank for your referral? _____

Describe your present dental problems _____

PLEASE PROVIDE CURRENT MEDICATIONS (PRESCRIPTIONS) _____

Are you allergic to any medications/materials? _____

CHECK YES OR NO

PATIENT MEDICAL HISTORY

☐ YES ☐ NO Are you under any medical treatment now?

☐ YES ☐ NO Have you had any major operations?

What? When? _____

☐ YES ☐ NO Have you ever had an accident involving head or jaw?

☐ YES ☐ NO Have you ever had any of the following:

- ☐ Heart Problems
- ☐ Heart Murmurs
- ☐ High or Low Blood Pressure
- ☐ Respiratory Disease
- ☐ TB
- ☐ Diabetes
- ☐ Arthritis
- ☐ Tumors/Growths Cancer
- ☐ Bleeding Disorder
- ☐ Liver Disease/Hepatitis
- ☐ Kidney Disease
- ☐ Digestive Disorder
- ☐ Venereal Disease
- ☐ HIV/AIDS
- ☐ Epilepsy
- ☐ Psychiatric Care
- ☐ Chemical Dependency
- ☐ Glaucoma
- ☐ Chemotherapy/Radiation

☐ YES ☐ NO Are you pregnant? Nursing?

☐ YES ☐ NO Do you have a history of fainting?

☐ YES ☐ NO Have you received any donor organs, artificial heart valves, vessels, joint implants, or use a pacemaker?

☐ YES ☐ NO Do you use cigarettes, cigars, snuff, chewing tobacco?

☐ YES ☐ NO Do you have any other problems not listed above?

_____

_____

_____

PATIENT DENTAL HISTORY

☐ YES ☐ NO Are you happy with the appearance of your teeth?

☐ YES ☐ NO Do you wish to keep your natural teeth?

☐ YES ☐ NO Have you ever had a bad dental experience?

☐ YES ☐ NO Have you had regular dental check-ups in the past?

How often? _____

When was your last full mouth X-ray taken? _____

Where? _____

☐ YES ☐ NO Do you have any pain in or near your ears?

☐ YES ☐ NO Do you have any blisters, growths, or sore spots in or around your mouth?

☐ YES ☐ NO Does any part of your mouth hurt when clenched?

☐ YES ☐ NO Do you habitually clench or grind teeth, day or night?

☐ YES ☐ NO Have you had any prolonged bleeding after extractions?

☐ YES ☐ NO Do your gums bleed?

☐ YES ☐ NO Any part of your mouth sore to pressure or irritants, such as cold, hot, sweets, etc.?
If so, locate? _____

☐ YES ☐ NO Any history of orthodontics - braces?

IF PATIENT HERE FOR DENTURES, PLEASE ANSWER

☐ YES ☐ NO Have you had previous dentures?

If so how many? _____

When last set made? _____

When were teeth removed? _____

COMMENTS:

CERTIFICATION: I certify that the answers given are correct to the best of my knowledge.

Signature _____ **Date** _____

– OVER –

IF PATIENT IS CHILD, PLEASE ANSWER

☐ YES ☐ NO Any history of thumbsucking, mouthbreathing, nailbiting, or unusual speech patterns?

☐ YES ☐ NO Has child had fluoridated water or fluoride supplements?

If so, how long? _____

PATIENTS WITHOUT INSURANCE

Full payment is due at the time of service. A 1.5% interest fee will be applied monthly to accounts unpaid.

PATIENTS WITH INSURANCE

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. **WE ARE NOT A PARTY TO THIS CONTRACT.** We file claims to your primary insurance carrier if all the necessary information is made available. As a service to you, our office ***estimates*** the financial portion your insurance company could pay for your dental treatment. We expect your estimated financial portion to be paid at the time dental treatment is rendered. This office is **NOT** In-Network with any insurance companies. You are ultimately **responsible** for any **unpaid balance**. For unpaid accounts, a **1.5% interest fee will be applied monthly.**

Dental Insurance Company _____ Policy #: _____

Policy Holder _____

Name Address DOB SS#

Policy Holder Employer _____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize payment of dental benefits to Dr. McCarthy for dental services rendered. I further authorize the release of any medical information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I agree to pay, in current manner, any balance of said professional service charges over and above this insurance payment. I realize that an account over 3 months old may be turned over to a third party collection agency.

I authorize the following people to access my information, including: financial billing & dental treatment _____

Relationship to patient _____

Signature _____ Date _____

Relationship to patient _____

MEDICAL HISTORY RECERTIFICATION

I certify that there have been no changes in my health except as noted below:

DATE	CHANGE	SIGNATURE