



Thank you for trusting us with your dental care!

Patient Information

Name: Birthdate: Mobile Phone: Address: City: State: Zip: Email: Alternate Phone:

Gender: M F Status: Minor Single Married Separated Widowed

Parent/Guardian Name (leave blank if patient is an adult): Spouse's Name (leave blank if not married): Spouse's Birthdate: Spouse's Employer:

*If patient is a minor, use parent/guardian information for the following:

Employer/School: Employer/School Address: City: State: Zip: Person to contact in case of emergency: Phone: How did you hear about us?

Insurance Information (Only for Insurance in Patient's Own Name)

Social Security #: *Needed to verify insurance. Will be kept private. Insurance Company: Group #: Member ID#: Address: City: State: Zip:

Insurance Information (Only for Insurance Under Another Name)

Insured's Name: Insured's Birthdate: Insured's Social Security #: *Needed to verify insurance. Will be kept private. Relation to Patient: Employer: Work Phone: Insurance Company: Group #: Member ID#: Address: City: State: Zip:

Additional Insurance (Only If You Have 2 Insurances)

Insured's Name: Insured's Birthdate: Insured's Social Security #: *Needed to verify insurance. Will be kept private. Relation to Patient: Employer: Work Phone: Insurance Company: Group #: Member ID#: Address: City: State: Zip:

Payment Due in Full At Time of Treatment (unless otherwise arranged)

I understand that I am responsible for payment of services rendered and for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

Print Name: Signature: Date:

(In adobe, right click, then certify with visible signature) (If you have problems, please e-mail without signature)

Dental History

Reason for today's visit: _____ Date of last dental care: _____
Former Dentist: _____ Date of last dental x-rays: _____
How often do you floss? _____ How often do you brush? _____
Do you like your smile? Yes No If no, why? _____
Would you like to change your smile? Yes No How? _____

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to Hot |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose Teeth or Broken Fillings | <input type="checkbox"/> Sensitivity to Sweets |
| <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sensitivity When Biting |
| <input type="checkbox"/> Food Collecting Between Teeth | <input type="checkbox"/> Sensitivity to Cold | <input type="checkbox"/> Sores or Growths in Your Mouth |

Medical History

Physician's Name: _____ Date of Last Visit: _____
Have you taken bisphosphonate medication? (Fosamax, Actonel, Atelvia, Didronel, Boniva) Yes No
Have you taken "fen-phen" drugs? (Ionimin, Adipex, Fastin, Pondimin, Redux) Yes No
Have you had any serious illnesses or operations? Yes No If yes, describe: _____
Have you had a blood transfusion? Yes No If yes, describe: _____
(Women) Are you pregnant? Yes No Nursing? Yes No On Birth Control? Yes No

Please check to indicate if you have had any of the following:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cough Up Blood | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herpes | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Cold Sore/Fever Blisters | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Yellow Jaundice |

List medicines you are taking and why: _____
List any allergies you have: _____

Disclaimer and Signature

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any staff member responsible for any errors or omissions that I may have made in the completion of this form.

Print Name: _____ Signature: _____ Date: _____
(In adobe, right click, then certify with visible signature)
(If you have problems, please e-mail without signature)

MAUMELLE FAMILY DENTISTRY

Acknowledgement of Receipt of Notice of Privacy Practice

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

(Please Print Name)

(Signature)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign.
- Communications barriers prohibited obtaining the acknowledgement
- An emergency prevented us from obtaining acknowledgement
- Other (Please Specify)
