MAUMELLE FAMILY DENTISTRY

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? _____

☐ Bad Breath	☐ Grinding Teeth	☐ Sensitivity to Hot
☐ Bleeding Gums	☐ Loose Teeth or Broken Fillings	☐ Sensitivity to Sweets
☐ Clicking or Popping Jaw	☐ Periodontal Treatment	☐ Sensitivity When Biting
☐ Food Collecting Between Teeth	☐ Sensitivity to Cold	☐ 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:

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