MABRY FAMILY DENTISTRY - PATIENT INFORMATION

Name: _____
(First) (Middle Initial) (Last)

Home Number :_____ Work Number:_____ Cell Phone:_____

Soc. Sec #:_____ Birthdate: _____ Sex: M____ F_____

Single _____ Married_____ Widowed _____ Divorced _____

Address:_____ City :_____State:_____ Zip_____

E-Mail _____ Employer _____Occupation_____

EMERGENCY CONTACT:_____ PHONE NUMBER_____

Confirm my appointments by: (choose one) _____ text message _____ email _____ phone call

Parent's Name (if child) _____ Phone:_____ Employed By:_____

Spouse's/Name:_____ Phone:_____ Employed By:_____

Business Address:_____ Business Phone: _____Ext:_____

How did you hear about our office?_____ Reason for visit:_____

DENTAL INSURANCE

Insured Name :_____

Home Phone:_____ Work Phone:_____Cell Phone/Beeper _____

Relation to Patient:_____ Birthdate:_____ Soc. Sec # _____

Address (IF DIFFERENT THAN PATIENT'S)_____

Insured Employed By:_____ Occupation _____

Dental Insurance Company:_____

Subscriber I.D.#:_____ Group #:_____

ADDITIONAL INSURANCE

Is patient covered by another Dental Insurance plan: Yes ___ No __

Subscriber Name:_____ Relationship to Patient_____ Birthdate_____

Soc. Sec #_____ Home Phone_____ Work Phone_____ Cell Phone_____

Address (IF DIFFERENT THAN PATIENT'S)_____

Dental Insurance Company:_____ Subscriber I.D.#_____ Group #_____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for dental services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pending of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original)

SIGNATURE PATIENT OR LEGAL GUARDIAN:_____ **DATE:_____**

PATIENT'S NAME: _____
LAST FIRST MIDDLE INITIAL
Reason for today's visit:_____

Former Dentist:_____ Reason for Leaving:_____ Date of last dental care_____ Last dental x-rays_____
Check ( ) if you have had problems with any of the following:

____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 collection between teeth	____ Sensitivity to cold	____ Sores or growths in mouth
____ Chipped or broken teeth		

How often do you floss? _____ How often do you brush? _____ Do you smoke?_____
Do you take any herbs?_____ Name the herbs you take _____
Have you had any side effects from herbs?_____ Explain_____

Our office, **upon recommendation of the American Dental Association**, applies Topical Fluoride **every 6 months** to aid in the prevention of tooth decay**, through the age of 12 years**. **Most dental insurance companies will cover this procedure once a year**. Please check one box and sign: ____ **Yes**, I understand and give my consent to the application of Fluoride **every 6 months**.
____ **No**, I refuse the application of Fluoride every 6 months as recommended by the American Dental Association.

MEDICAL HISTORY

Physician's name_____ Date of last visit_____

Have you had any serious illnesses or operations? _____ Describe_____

Have you ever had a blood transfusion? Yes____ No____ if yes, give approximate date_____

Has your Physician ever told you that you need to take Antibiotics (Pre-Med) prior to having any dental work done due to recent joint replacement, heart surgery, etc. Yes_____ No_____

(Women) Are you pregnant Yes____ No____ Nursing? Yes___ No___ taking birth control pills? Yes____ No____

Check ( ) if you have had any of the following:

____ AIDS	____ Cortisone Treatments	____ Hepatitis	____ Rheumatic Fever
____ Anemia	____ Cough, Persistent	____ High blood pressure	____ Scarlet Fever
____ Arthritis, Rheumatism	____ Cough up blood	____ High Cholesterol	____ ADD/ADHD
____ HIV positive	____ Diabetes	____ **Artificial Heart Valves**	____ Seizures
____ Jaw pain	____ Skin rash	____Migraines	____ Reflux
____ **Artificial Joints**	____ Epilepsy	____ Kidney disease	____ Stroke
____ Asthma	____ Fainting	____ Liver disease	____ Swelling feet/ankles
____ Back Problems	____ Glaucoma	____ Mitral Valve Prolapse	____ Thyroid problems
____ Blood Disease	____ Headaches	____ Nervous Problems	____ Tobacco habit
____ Cancer	____ Heart Murmur	____ Pacemaker	____ Tonsillitis
____ Chemical Dependency	____ Heart Problems	____ Psychiatric Care	____ **Tuberculosis**
____ Chemotherapy	Describe:_____	____ Radiation Treatment	____ Ulcer
____ Circulatory Problems	____ **Hemophilia/Excessive Bleeding**	____ Respiratory Disease	____ Venereal disease
		____ **Sleep Apnea**	**ALLERGIES**

List medications you are taking:_____
_____
_____
_____

____ Aspirin	____ Penicillin
____ Barbiturates (Sleeping Pills)	____ Sulfa drugs
____ Codeine	____ Other_____
____ Local anesthetic	_____
____ **Latex**	

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

DATE:_____ SIGNATURE:_____