MyMouthDental
LET OUR FAMILY TREAT YOURS

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PATIENT INFORMATION

Date ______________ DL # ______________ SS # ______________

Patient Name ____
Last Name

First Name Middle Initial "Preferred"

Address ____

City ____

State ____________________ Zip ____________________

Phone #'s: Home____________Work____________Cell____________

E-mail ____

Sex O M O F Age______ Birth Date ____________________

O Married O Widowed O Single

O Minor O Separated O Divorced

Patient Employer / School ______________________________

Occupation / Hobby ______________________________

Employer / School Address ______________________________

Employer/School Phone (______) ______________________

Spouse's Name ______________________________

Birth Date ______________________________

SS # ______________________________

Spouse's Employer ______________________________

Whom may we thank for referring you? ______________________

INSURANCE INFORMATION

Who is responsible for this account? ______________________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________ Phone # ______________

Is patient covered by additional insurance? O Yes O No

Subscriber's Name ______________________

Birth Date ______________ SS # ______________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________ Phone # ______________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to
Name of Insurance Company(ies)

Dr. ______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining Insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please Print name of Patient, Parent, Guardian or Personal Representative

DENTAL INFORMATION

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Reason for today's visit ______________
____

Former Dentist ______________

City/State ______________

Date of last dental visit ______________

Date of last dental X-rays ______________

• Bleeding gums	O Yes	O No	• Gums swollen or tender	O Yes	O No
• Periodontal treatment	O Yes	O No	• Loose teeth or broken fillings	O Yes	O No
• Chew on one side of mouth	O Yes	O No	• Pain around ear	O Yes	O No
• Cigarette, pipe, or cigar smoking	O Yes	O No	• Sensitivity to biting	O Yes	O No
• Clicking or popping jaw/jaw pain	O Yes	O No	• Sensitivity to cold/heat/sweets	O Yes	O No
• Dry mouth	O Yes	O No	• Are you happy with your smile?	O Yes	O No
• Food collection between teeth	O Yes	O No	• Would you like your teeth whiter?	O Yes	O No
• Grinding teeth	O Yes	O No	• How often do you floss? ______________		

-OVER-

HEALTH HISTORY

Physician's Name / Phone # ____ Date of last visit _________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). O Yes O No

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
● AIDS/HIV	O Yes	O No	● Diabetes	O Yes	O No	● Liver Disease	O Yes	O No
● Arthritis / Rheumatism	O Yes	O No	●Emphysema / Breathing or Lung Problems	O Yes	O No	● Pacemaker	O Yes	O No
● Artificial Heart Valves	O Yes	O No	● Epilepsy	O Yes	O No	● Stroke	O Yes	O No
● Artificial Joints	O Yes	O No	● Glaucoma	O Yes	O No	● Swollen Feet or Ankles	O Yes	O No
● Asthma	O Yes	O No	● Headaches	O Yes	O No	● Swollen Neck Glands	O Yes	O No
● Bleeding abnormally, with extractions or surgery	O Yes	O No	● Heart Murmur / MVP	O Yes	O No	● Thyroid Problems	O Yes	O No
● Cancer	O Yes	O No	● Heart Problems _____	O Yes	O No	● Tuberculosis	O Yes	O No
● Chemical Dependency	O Yes	O No	● Hepatitis Type ______	O Yes	O No	● Tumor or Growth on head or back	O Yes	O No
●Chemotherapy / Radiation	O Yes	O No	● High Blood Pressure	O Yes	O No	● Ulcer	O Yes	O No
● Cortisone Treatments	O Yes	O No	● Kidney Disease	O Yes	O No			

Have you ever taken osteoporosis medication such as Fosamax? O Yes O No

Have you ever been told you need to take an antibiotic premed before any dental visit? O Yes O No

Do you have any other medical concerns? ____

Women:

Are you pregnant? O Yes O No Due Date: ______________________ Are you nursing? O Yes O No

Taking birth control pills? O Yes O No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

____

____

Pharmacy Name: ____

Phone: (________)____

ALLERGIES

O Aspirin

O Barbiturates (Sleeping pills)

O Codeine

O Iodine

O Latex

O Local Anesthetic

O Penicillin

O Sulfa

O Other __________________

____

IN CASE OF EMERGENCY CONTACT:

Name _____________________________________ Relationship ______________________________ Phone # ______________________

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

Print Name Signature Date

------ FOR OFFICE USE ONLY ------

We attempted to obtain written acknowledgment 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 situation prevented us from obtaining the acknowledgement
_____ Other (Please Specify)