MARSH FAMILY DENTAL

Patient Information

Patient Name:_____ Date:_____

Birthdate: _____ Social Security #:_____

Drivers Lic.:_____ E-mail:_____

Address:_____
Street Apt.

_____
City State Zip

Home Phone:_____ Cell Phone:_____

Referral Information

Whom may we thank for referring you to our office? _____

Spouse or Responsible Party

Name:_____ Relationship:_____

Birthdate: _____ Social Security #:_____

Drivers Lic.:_____ E-mail:_____

Address:_____
Street Apt.

_____
City State Zip

Home Phone:_____ Cell Phone:_____

Primary Insurance Information

Name of Insured:_____ Birthdate:_____

Employer:_____

Insurance Company:_____

Subscriber ID:_____

Group Number:_____

Secondary Insurance Information

Name of Insured:_____ Birthdate:_____

Employer:_____

Insurance Company:_____

Subscriber ID:_____

Medical Information

Please indicate if you have or have had any of the following diseases or problems.

Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Y N

Are you taking or scheduled to begin taking either of the medications, alendronate **(Fosamax)** or risedronate **(Actonel)** for osteoporosis or Paget's disease? Y N

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphontes **(Aredia or Zometa)** for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Y N

WOMEN ONLY - Are you:
Taking birth control pills or hormonal replacement? Y N
Pregnant? Y N
If yes, number of weeks _____

Allergies - Are you allergic to or have had a reaction to:

Acrylic	Y	N
Aspirin	Y	N
Codeine	Y	N
Erythromycin	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Tetracycline	Y	N
Metals:		
If yes, specify: _____	Y	N
Other allergy not listed:		
If yes, specify: _____	Y	N

List any prescription or over the counter medicine(s) you are presently taking: _____

Please indicate if you have or have had any of the following diseases or problems.

Artificial (Prosthetic) Heart Valve	Y	N
Previous Infective Endocarditis	Y	N
Damaged Valves in Transplanted Heart	Y	N
Congenital Heart Disease (CHD):		
Unrepaired, cyanotic CHD	Y	N
Repaired (completely) in last 6 months	Y	N
Repaired CHD with residual defects	Y	N

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Cardiovascular Disease	Y	N
Angina	Y	N
Congestive Heart Failure	Y	N
Damaged Heart Valves	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
Low Blood Pressure	Y	N
High Blood Pressure	Y	N
Other Congenital Heart Defects	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N
Rheumatic Fever	Y	N
Rheumatic Heart Disease	Y	N
Abnormal Bleeding	Y	N
Anemia	Y	N
Coumadin/Blood Thinner Therapy	Y	N
AIDS or HIV Infection	Y	N

Arthritis	Y	N
Autoimmune Disease	Y	N
Rheumatoid Arthritis	Y	N
Systemic Lupus Erythematosus	Y	N
Asthma	Y	N
Emphysema	Y	N
Tuberculosis	Y	N
Pulmonary Shunts	Y	N
Cancer/Chemotherapy/Radiation Treatment	Y	N
Diabetes	Y	N
Fen-Phen (fenfluramine/phentermine) Therapy	Y	N
Eating Disorder	Y	N
Gastrointestinal Disease/Stomach Problems	Y	N
Thyroid Problems	Y	N
Stroke	Y	N
Hepatitis, Jaundice or Liver Disease	Y	N
Kidney Problems	Y	N
Sexually Transmitted Disease	Y	N
Osteoporosis	Y	N
Drug/Alcohol Abuse	Y	N
Epilepsy	Y	N
Neurological Disorders		
If yes, specify: _____	Y	N
Mental Health Disorders		
If yes, specify: _____	Y	N
Other medical condition not listed:		
If yes, specify: _____	Y	N

Have you had any previous hospitalizations or surgeries? Y N If yes, specify: _____

Are you currently under the care of a physician? Y N If yes, please explain: _____

List the name of your physician and phone number: _____

List the name and phone number of someone to notify in case of an emergency: _____

Authorization and Consent

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes. I hereby consent to and authorize the dental office to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. 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 further understand that payment is due at the time of treatment unless prior arrangements have been made. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

Patient or Responsible Party Signature: _____ Date: _____

Office Use Only

I verbally reviewed the medical/dental information with the patient named herein.

Dentist Signature: _____ Date: _____

Dental History

Primary reason for this appointment: ☐ *Examination* ☐ *Emergency* ☐ *Consultation*

Patient Name:_____ **Date:**_____

(The following responses are for the patient)

Do you have a specific dental problem today? ..... Y N

If yes, please explain:_____

Do you have dental examinations on a routine basis? ..... Y N

Last visit?:_____

Do you brush your teeth on a routine basis? ..... Y N

How often?:_____

Do you floss on a routine basis? ..... Y N

How often?:_____

Do you like your smile? ..... Y N

If no, why?:_____

Do you think you have active tooth decay? ..... Y N

Do you think you have gum disease? ..... Y N

Do your gums bleed? ..... Y N

Do you have any loose teeth? ..... Y N

Have you ever had any periodontal (gum) treaments? ..... Y N

If yes, when?:_____ where?:_____

Do you want to keep your remaining teeth? ..... Y N

Do you ever have clicking, popping, or discomfort in the jaw joint? ..... Y N

Do you brux or grind your teeth? ..... Y N

Do you smoke or chew tobacco? ..... Y N

Have you ever had orthodontic (braces) treatment? ..... Y N

Do you wear dentures or partials? ..... Y N

If yes, are you satisfied with them?:_____

Have you had any problems associated with previous dental treatment? ..... Y N

If yes, please explain: _____

_____

Name of previous dentist (optional):_____

Date of last full mouth x-rays (16 small films or panoramic):_____

To the best of my knowledge, I certify that the information given above is correct.

Signature of Patient/Legal Guardian:_____

Dentist Signature:_____

Medical History Update (For Office Use Only)

Date:_____ Comments:_____ Initials:_____

Date:_____ Comments:_____ Initials:_____

Date:_____ Comments:_____ Initials:_____

Date:_____ Comments:_____ Initials:_____

Date:_____ Comments:_____ Initials:_____