WELCOME TO MURPHY FAMILY DENTAL

Patient Information:

Date_____ Last Name_____ First Name _____

Home Phone ( ) _____ Cell ( ) _____SSN_____

Address_____ Sex_____M _____F

City_____ State_____ Zip_____ Birth Date_____

Drivers License #_____ Married _____Single _____Minor_____

Email address _____

How will you be paying for your visit today?____Cash/Check ___Credit Card

Employer/Student_____ Occupation_____

Employer Address_____ Work #_____

May we contact you at work? _____ Y _____N

Insurance Subscriber/Person Responsible for Account

Name_____ SSN_____

Relation to patient_____ Birth Date_____ Phone #_____

Employer_____ Occupation_____

Employer Address_____ Work #_____

Patient Insurance

Are you covered by dental insurance? ____Y ____N Insurance Carrier Name_____

Group # _____ Subscriber ID_____ Contract #_____

Names of other dependents covered by this plan_____

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

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

This dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of three months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment. I authorize release of all information necessary to secure payment, as well as payment to be made directly to the dentist from my insurance company. I authorize the Doctor and staff to take needed radiographs and perform diagnostic procedures and examinations as deemed necessary by the Doctor to make a thorough diagnosis of my (or my child's) dental needs. I authorize the Doctor and staff to perform mutually agreed upon treatment and procedures and to use medications and aesthetic agent as may be necessary.

I understand that any medications used, including anesthetic agents embodies some risk. I further understand that unforeseen conditions can arise during treatment which may call for procedures in addition to, or different from, those originally contemplated and I will be informed, whenever possible, prior to these additional or changed procedures.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date:_____

So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health. Please complete this medical history form. This information is, of course, confidential.

Patient Name: _____ Date of Birth _____ Age: _____ ☐ Male ☐ Female

Address _____ Weight _____ Home Phone No. _____

_____ Height _____ Work Phone No. _____

_____ SSN # _____ Cell Phone No. _____

If you are completing this form for another person, what is your relationship to that person? Your Name _____ Relationship _____

MEDICAL HISTORY

Physician's Name _____

Address _____

Are you now under the care of a physician? YES ☐ NO ☐

If yes, for what reason? _____

Are you presently taking any medications / drugs / pills? YES ☐ NO ☐

List all medications prescribed by your physician (including birth control pills), vitamins, herbal supplements, natural products, over-the-counter drugs taken routinely and controlled substances.

_____

_____

_____

_____

_____

_____

_____

ALLERGIES / SENSITIVITIES:

Are you allergic / sensitive (or ever had an adverse reaction) to: *Check all that apply or check none*

☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Metals ☐ LATEX

☐ Aspirin ☐ Other Antibiotics ☐ Other Medications or Substances ☐ **NONE**

Do you have, or have you ever had any of the following: (YES or NO)

	YES	NO		YES	NO		YES	NO		YES	NO
1 Artificial (prosthetic) heart valve	☐	☐	13 Anorexia	☐	☐	29 Drug Dependency	☐	☐	45 Autoimmune Disease	☐	☐
2 Previous infective endocarditis	☐	☐	14 Bulimia	☐	☐	30 Chemical Dependency	☐	☐	46 Artificial Joint / Prosthesis	☐	☐
3 Damaged valves in transplanted heart	☐	☐	15 Lung disease / COPD	☐	☐	31 Blood Disorders	☐	☐	47 Liver Disease	☐	☐
4 Congenital heart disease (CHD)			16 Tuberculosis	☐	☐	32 Anemia	☐	☐	48 Hepatitis (circle one)	☐	☐
Unrepaired, cyanotic CHD	☐	☐	17 Asthma	☐	☐	33 Leukemia	☐	☐	Type A B C Other		
Repaired (completely) in last 6 months	☐	☐	18 Shortness of Breath	☐	☐	34 Prolonged Bleeding	☐	☐	49 Ulcers	☐	☐
Repaired CHD with residual defects	☐	☐	19 Respiratory Ailments	☐	☐	35 Hemophilia	☐	☐	50 Gastrointestinal Disease	☐	☐
5 Heart Disease/Surgery	☐	☐	20 Emphysema	☐	☐	36 Sickle Cell Disease	☐	☐	51 GERD (gastric reflux)	☐	☐
6 Heart murmur	☐	☐	21 Sinus Trouble	☐	☐	37 Cancer	☐	☐	52 Hearing Impaired	☐	☐
7 Heart pacemaker	☐	☐	22 Diabetes Type I or Type II	☐	☐	38 Tumors	☐	☐	53 Glaucoma	☐	☐
8 Rheumatic fever/heart disease	☐	☐	23 Thyroid Problems	☐	☐	39 Chemotherapy	☐	☐	54 Cortisone Medication	☐	☐
9 Mitral valve prolapse	☐	☐	24 Persistent swollen glands	☐	☐	40 Radiation Therapy	☐	☐	55 Fainting Spells	☐	☐
10 High/low blood pressure	☐	☐	25 Kidney Problems	☐	☐	41 Neurological Disorders	☐	☐	56 Organ Transplant	☐	☐
11 Learning Disability	☐	☐	26 Venereal Disease	☐	☐	42 Epilepsy	☐	☐	57 Removal of Spleen	☐	☐
12 Mental Health Disorder	☐	☐	27 HIV Positive / AIDS / ARC	☐	☐	43 Stroke	☐	☐	58 Osteoporosis	☐	☐
			28 Alcohol Addiction	☐	☐	44 Arthritis / Rheumatism	☐	☐	59 Sleep Disorder	☐	☐

BISPHOSPHONATES

Have you ever or are you currently taking or scheduled to begin taking any of the medications, alendronate (Fosamax®), risedronate (Actonel®) or ibandronate (Boniva®) for **osteoporosis** or Paget's disease? ☐ YES ☐ NO

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ YES ☐ NO Date Treatment Began _____/_____/_____

DR COMMENTS

BLOOD PRESSURE

/

Have you ever used or currently use tobacco products? ☐ YES ☐ NO How much? _____ How Often? _____

☐ cigarettes ☐ cigars ☐ pipe ☐ chew How long ago did you quit? _____

Do you drink alcoholic beverages? ☐ YES ☐ NO How much? _____ How often? _____

Have you had any other serious illness, hospitalization or accident? ☐ YES ☐ NO

If yes, please explain _____

WOMEN: Are you pregnant or suspect that you may be? ☐ YES ☐ NO

Are you nursing? ☐ YES ☐ NO

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 health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient Signature _____ Date _____

(PARENT/GUARDIAN)

Doctor Signature _____ Date _____

MEDICAL HEALTH HISTORY NAME _____ # _____