WELCOME

DR. DAVID MORAN. DMD
DR. KERRY GALLAGHER, DMD
DR. KRYSITAN JAROSZ, DMD, MDS

PATIENT INFORMATION

PATIENT NAME: ____ DATE: ___________
FIRST NAME LAST NAME

BIRTHDATE: _______________ SEX : M / F AGE: ____________ SS# : ___________________

ADDRESS: ___________________________ CITY: _________________ STATE: _______ ZIP: ________

HOME PHONE: ______________ CELLPHONE: ________________ WORK PHONE: ____________________

PATIENT EMPLOYER/SCHOOL: _________________________ ADDRESS: __________________________

PATIENT EMPLYER/SCHOOL PHONE#: _________________ OCCUPATION: ________________________

MARITAL STATUS : MARRIED___ SINGLE ___ WIDOWED ___ DIVORCED ___ PARTNERS ____

SPOUSES NAME: _________________________ BIRTHDATE: __________ SS#: ____________________

SPOUSES EMPLOYER: ____________________

WHOM MAY WE THANK FOR REFERRING YOU? ____________________

DENTAL INSURANCE

WHO IS RESPONBILE FOR THIS ACCOUNT: _______________

RELATIONSHIP TO PATIENT: ____________________

INSURANCE COMPANY: _______________ GROUP#: ______

POLICY HOLDER: ____________________ ID#: _______

BIRTHDATE: _________________ SS#: _____________

RELATIONSHIP TO PATIENT: _______________________

DO YOU HAVE AN ADDITIONAL INSURANCE? YES____ NO_____

POLICY HOLDER: _______________________

INSURANCE COMPANY: _____________ GROUP #: _______

ID #: _______________ EMPLOYER: _______________

ASSIGNMENT AND RELEASE:

I CERTIFY THAT I, AND/OR MY DEPENDENT(S) HAVE INSURANCE COVERAGE WITH ____________________ AND ASSIGN DIRECTLY TO DR. _______________ INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES REMDERED. 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 OR GUARDIAN

____________________________________ DATE: _________
PRINTED NAME OF PATIENT OR GUARDIAN

IN CASE OF EMERGENCY

NAME: ______________________________ RELATIONSHIP: ___________________________

PHONE: _____________________________ ALTERNATIVE PHONE: ______________________

DENTAL HISTORY

REASON FOR TODAYS VISIT: ____

FORMER DENTIST: ____________________________ CITY: ______________________ STATE: __________

DATE OF LAST DENTAL VISIT: _______________ DATE OF LAST DENTAL XRAYS: _______________

PLACE A MARK ON THE LINE IF YOU HAVE ANY OF THE FOLLOWING:

____ **BAD BREATH**
____ **BLEEDING GUMS**
____ **BLISTERS ON LIPS/MOUTH**
____ **BURNING SENSATION ON TONGUE**
____ **CHEW ON ONE SIDE OF MOUTH**
____ **CIGARETTE/PIPE/CIGAR SMOKING**
____ **CLICKING OR POPPING JAW**
____ **DRY MOUTH**
____ **FINGERNAIL BITING**
____ **FOOD COLLECTION BETWEEN TEETH**
____ **FOREIGN OBJECTS**
____ **GRINDING TEETH**
____ **GUMS SWOLLEN OR TENDER**
____ **JAW PAIN OR TIREDNESS**
____ **LIP OR CHEEK BITING**
____ **LOOSE TEETH OR BROKEN FILLINGS**
____ **MOUTH BREATHING**
____ **MOUTH PAIN WHEN BRUSHING**
____ **ORTHODONTIC TREATMENT**
____ **PAIN AROUND EAR**
____ **PERIODONTAL TREATMENT**
____ **SENSITIVITY TO COLD**
____ **SENSITIVITY TO HEAT**
____ **SENSITIVITY TO SWEETS**
____ **SENSITIVITY TO BITING**
____ **SORES OR GROWTHS IN YOUR MOUTH**

HOW OFTEN DO YOU FLOSS: _______________

HOW OFTEN DO YOU BRUSH: _______________

MEDICAL HISTORY

ARE YOU UNDER A PHYSICIAN'S CARE NOW? ____ YES ____ NO IF YES, WHY? ______________________

HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR SURGERY? ____ YES ____ NO IF YES, WHY? ______________________

HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY? ____ YES ____ NO IF YES, EXPLAIN: ______________________

DO YOU TAKE, OR HAVE YOU TAKEN, PHEN - FEN OR REDUX? ____ YES ____ NO IF YES, EXPLAIN: ______________________

HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY OTHER MEDICATIONS CONTAINING BISPHOSPHONATES? ____YES ____ NO IF YES, EXPLAIN: ______________________

ARE YOU ON A SPECIAL DIET? ____ YES ____ NO

ARE YOU PREGNANT OR TRYING TO GET PREGNANT? ____ YES ____ NO

DO YOU USE TOBACCO? ____ YES ____ NO

DO YOU USE CONTROLLED SUBSTANCES? ____ YES ____ NO

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? ____ ASPIRIN ____ PENICILLIN ____ CODEINE ____ ACRYLIC ____ METAL ____ LATEX ____ SULFA DRUGS ____ LOCAL ANESTHICS OTHER __________

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

____ AIDS/ HIV POSITIVE
____ ALZHEIMERS
____ ANAPHYLAXIS
____ ANEMIA
____ ANGINA
____ ARTHRITIS/GOUT
____ ARTIFICIAL HEART VALVE
____ ARTIFICIAL JOINT
____ ASTHMA
____ BLOOD DISEASE
____ BLOOD TRANSFUSION
____ BREATHING PROBLEMS
____ BRUISE EASILY
____ CANCER
____ CHEMO THERAPY
____ CHEST PAINS
____ COLD SORES/ FEVER BLISTERS
____ CONGENITAL HEART DISORDER
____ CONVULSIONS
____ CORTISONE MEDICINE
____ DIABETES
____ DRUG ADDICTION
____ EASILY WINDED
____ EMPHYSEMA
____ EPILEPSY/ SEIZURES
____ EXCESSIVE BLEEDING
____ EXCESSIVE THIRST
____ DIZZINESS
____ FREQUENT COUGH
____ FREQUENT DIARRHEA
____ GENITAL HERPES
____ GLAUCOMA
____ HAY FEVER
____ HEART ATTACK/ FAILURE
____ HEART MURMUR
____ HEAR PACEMAKER
____ HEART TROUBLE/ DISEASE
____ HEMOPHILIA
____ HEPATITIS A
____ HEPATITIS B/C
____ HERPES
____ HIGH BLOOD PRESSURE
____ HIGH CHOLESTEROL
____ HIVES OR RASH
____ HYPOGLYCEMIA
____ IRREGULAR HEARTBEAT
____ KIDNEY PROBLEMS
____ LEUKEMIA
____ LIVER DISEASE
____ LOW BLOOD PRESSURE
____ LUNG DISEASE
____ MITRAL VALVE PROLAPSE
____ OSTEOPOROSIS
____ PAIN IN JAW JOINTS
____ PARATHYROID DISEASE
____ PSYCHIATRIC CARE
____ RADIATION TREATMENTS
____ RECENT WEIGHT LOSS
____ RENAL DIALYSIS
____ RHEUMATIC FEVER
____ RHEUMATISM
____ SCARLET FEVER
____ SHINGLES
____ SICKLE CELL DISEASE
____ SINUS TROUBLE
____ SPINA BIFIDA
____ STOMACH/ INTESTINAL DISEASE
____ STROKE
____ SWELLING OF LIMBS
____ THYROID DISEASE
____ TONSILLITIS
____ TUBERCULOSIS
____ TUMORS OR GROWTHS
____ULCERS
____ VENEREAL DISEASE
____ YELLOW JAUNDICE

ANYTHING NOT LISTED: ______________

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR PATIENT'S) HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.

____
SIGNATURE OF PATIENT OR GUARDIAN

DATE: ______________________