Thank You For Selecting Our Dental Team.

We are pleased to welcome you to our practice. Please take a few minutes to complete the following information so we can better care for you. It is our goal to help you reach and maintain maximum oral health.

Name: _____

I prefer to be called _____

Male Female Married Single Other

Birth date____/____/____ S.S.#:_____

Home Address _____
City_____State____Zip_____

Hm # _____Cell # _____

Wk # _____ Pgr # _____

E-mail Address _____

Employer _____

Employer Address _____

_____

Occupation:_____

Mercy Care / Health Net / CMDP:
Guardian Info
Name:_____
Birthday:_____
SS #:_____

How would you prefer to be contacted?

Cell Hm Phone Wk Phone

Email Text Pgr

Whom may we thank for referring you?

_____

Other Family Members seen by us?

_____

Previous / Present Dentist:_____

Last Visit Date: ____/____/____

Ph#_____

In the events of an emergency, is there someone who lives near you that we should contact?

Name:_____

Relation:_____

Wk#:_____

Hm#:_____

Primary Dental Insurance

Insurance Co. Name:_____

Insurance Co. Phone #:_____

Group # (plan, Local or Policy#):_____

Insured's Name:_____

Relation _____

Insured's Birth date ____/____/____

Insured's S.S.# _____

Secondary Insurance Name:_____

Insurance Co. Phone #:_____

Insured's Name:_____

Relation_____ S.S.#:_____BD__/__/__

A note for our patients with dental insurance-

We will assist you in anyway possible to maximize your insurance benefits. We are happy to file claims to your insurance carrier and agree to accept payment from any carrier that offers an assignment of benefits, if you desire. We will do our best to make as close of a calculation as possible of what your insurance plan will cover, however regardless of what your insurance plan pays, you are responsible for all fees.

Initial x_____

Appointment Cancellation Policy-

Please help us to deliver the best quality dental care by keeping scheduled visits. If you are unable to keep your appointment give at least 24 hours notice. We reserve the right to charge $50.00 per hour for appointments canceled with less than adequate notice. I further agree to pay all finance charges, collection cost, attorney fees, and any other cost that may be incurred to enforce collection of any amount outstanding.

Initial x_____

Medical History

Are you currently under the care of a physician? If yes please describe.

Are you currently taking prescription or OTC drugs of any kind? If yes please list.

Women Only: Are you pregnant?_____ Are you nursing?_____

Are you taking oral contraceptives?_____

Do You have, have had, or been treated for, any of the following?:

Y N ARTHRITIS
Y N RHEUMATIC FEVER
Y N HEART PROBLEMS
Y N HIGH BLOOD PRESSURE
Y N LOW BLOOD PRESSURE
Y N ANEMIA, SICKLE CELLULAR
Y N EPILEPSY, SEIZURES
Y N CHEMICAL DEPENDENCY
Y N HEPATITIS A or B or C
Y N ULCERS
Y N KIDNEY DISORDER
Y N TUBERCULOSIS
Y N ANOREXIA, BULIMA
Y N PHEN-PHEN OR REDUX
Y N HEMOPHILIA, BLEEDING OR BLOOD DISORDER
Y N THYROID CONDITION
Y N VENEREAL DISEASE
Y N PACEMAKER
Y N HIP OR JOINT REPLACEMENT
Y N FAINTING SPELLS
Y N DIABETES
Y N RADIATION THERAPY
Y N EAR INFECTION
Y N CHONIC SINUS INFECTION
Y N ASTHMA
Y N AIDS RELATED COMPLEX
Y N HEART MURMUR
Y N MITRAL VALVE PROLAPSE

Do you have any reactions to or are you allergic to:

Y N LOCAL ANESTHETICS
Y N ASPIRIN OR IBUPROFEN (Advil)
Y N BARBITURATES OR TRANQUILIZERS
Y N CODEINE or other NARCOTICS
Y N LATEX MATERIALS
Y N PENICILLIN
Y N ERYTHROMYCIN
Y N ACETAMINOPHEN (Tylenol)
Y N SULFA DRUGS
Y N ANY OTHER MEDICATIONS OR DRUGS?

_____

Why have you come to the dentist today? _____

How would you describe the condition of your teeth or gums on a scale of 1 to 10? 10 being the best _____

Are you currently in pain or discomfort with your teeth and gums? Y or N

If yes, explain:_____

How often do you brush your teeth?_____ How often do you floss your teeth?_____

Do your gums bleed when you floss or brush your teeth? Y or N

Have you ever experienced pain in your jaw joint? Y or N

Do you use tobacco products? Y or N

I understand that the information is correct to the best of my knowledge and it will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status. I authorize the release of information for insurance purposes and give consent for Dr. Mullenaux and his staff to treat me. I authorize Dr. Mullenaux and/or his staff to take photos of my care and treatment, which may be used for the advancement and educational viewing by other dentists, staff or patients. Dr Mullenaux and his staff cannot reveal my identification without my permission. I am responsible for payment.

Signature:_____(If under 18 Parent or Guardian) Date:_____