MHM

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PRACTICE LIMITED TO PERIODONTICS AND DENTAL IMPLANTS

Welcome to our practice! Our goal is to provide you with the best quality of periodontal care. Please take a few minutes to fill out this form, as completely as possible. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date_____ Soc. Sec. #_____ Sex M ☐F ☐ Single ☐ Married ☐ Widowed ☐Separated ☐Divorced ☐

Name_____ Birth date_____

Address_____ Email_____

City_____State_____Zip_____

Home number_____ Cell phone_____

Whom may we thank for referring you? _____

Employed by_____ Employer's phone _____

Employers address_____

In case of emergency, who should be notified? _____Phone_____

PRIMARY DENTAL INSURANCE

Subscriber's name_____ Phone _____

Relation to patient_____ Birth date_____ Soc. Sec. #_____

Address (if different from patient's)_____

City_____ State_____ Zip_____

Member's employer_____ Employer's phone_____

Employer's address_____

Insurance company_____ Ins. Co. phone # _____

Group #_____ Subscriber #_____

SECONDARY INSURANCE

Is patient covered by additional insurance? ☐Yes ☐No Subscribers name_____

Soc Sec. #_____ Birth date_____ Home phone #_____

Address (if different from patient's)_____

City_____ State_____ Zip_____

Member's employer_____ Employer's phone #_____

Employer's address_____

Insurance company_____ Ins. Co. phone # _____

Group #_____Subscriber #_____

DENTAL HISTORY

Reason for today's visit_____

Dentist's name_____ Dentist phone #_____

City_____ Date of last dental visit_____ Date of last dental X-rays_____

Please check if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sores or growths
- ☐ Sensitivity to hot
- ☐ Sensitivity to cold
- ☐ Sensitivity when biting
- ☐ Sensitivity to sweets

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

MEDICAL HISTORY

Physician's name_____ Date of last visit_____

Physician's phone #_____Pharmacy name and #_____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, please describe_____

_____

Women: are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐No Taking birth control pills? ☐Yes ☐ No
Has your physician recommended taking antibiotics prior to dental visits? ☐ Yes ☐ No
Please check if you have had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Aspirin daily
- ☐ Asthma
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependence
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cortisone treatment
- ☐ Cough, persistent
- ☐ Cough up blood
- ☐ Coumadin
- ☐ Diabetes
- ☐ Epilepsy or seizures
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hemophilia/bleeding
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV positive
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Latex allergies
- ☐ Liver disease
- ☐ Mitral valve prolapse
- ☐ Nervous problems
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Psychiatric care
- ☐ Radiation therapy
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Stroke
- ☐ Swelling feet
- ☐ Thyroid problems
- ☐ Tobacco habit
  How much?_____
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal disease

MEDICATIONS BEING TAKEN: _____ _____

_____ _____ _____

_____ _____ _____

Allergies:_____ _____ _____

_____ _____ _____

AUTHORIZATION

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure payment of benefits.

I understand I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date_____

PAYMENT IS DUE IN FULL, AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE