MT. MORRIS
FAMILY DENTAL

About You

Today's Date: _____/_____/_____

Name:_____
LAST FIRST MI

Preferred Name:_____Marital Status: S M D W

Birthdate:_____/_____/_____ Age:_____ SSN:_____

Address:_____

_____
CITY STATE ZIP

Email:_____

Driver's License_____ SS#_____

Employer:_____

How long there?:_____ Occupation:_____

Home Phone:_____ Cell:_____

Work Phone:_____

Whom may we thank for referring you?:

_____

In the event of an emergency, whom would you like us to contact?

His/Her Name:_____

Relation: _____

Home Phone:_____ Cell:_____

Dental Insurance Information

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone : _____

Insured's ID #: _____

Group #: _____

Insured's Name: _____

Insured's SS#: _____

Insured's Birthdate: _____/_____/_____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Insured's ID #: _____

Group #: _____

Insured's Name: _____

Insured's SS#: _____

Insured's Birthdate: _____/_____/_____

Spouse Information

His/Her Name: _____

Employer: _____

Work Phone:_____Cell:_____

Birthdate: _____/_____/_____

(PLEASE COMPLETE BACK OF FORM)

Dental and Medical History

Previous General Dentist:_____ Last Visit:_____

What are the main concerns that you would like our office to accomplish?:_____

Are you currently in pain? Y / N Please specify: _____ Any pain in your jaw joint? Y / N

Have you experienced any unfavorable reaction from any previous dental care? Y / N Please specify: _____

Do you require antibiotics before dental procedures? Y / N If yes, please specify reason: _____

Family Physician:_____ Phone: _____

Address:_____

Your current physical health is: Good / Fair / Poor

Are you currently under a physician's care? Y / N If yes, explain: _____

Are you taking any medicine at this time? Y / N Please specify: _____

Are you allergic to any medications? Y / N Please specify: _____

Are you allergic to the following medications?

Yes / No Penicillin **Yes / No** Tetracycline **Yes / No** Erythromycin **Yes / No** Aspirin **Yes / No** Dental Anesthetics **Yes / No** Codeine **Yes / No** Sulfa

Do you have any known allergies (latex, nickel, nuts, etc.)? Y / N Please specify:_____

Have you been hospitalized or had any surgeries? Y / N Please specify:_____

Do you smoke? Y / N How much per day? _____ Do you chew tobacco? Y / N Do you vape? Y / N How much per day?___

Are you currently or have you previously taken bisphosphonates? Y / N If yes, explain: _____

Have you had a sleep study? Y / N Have you been diagnosed with sleep apnea? Y / N Do you wear a CPAP? Y / N

Do you have any history of these?:

Yes / No Heart attack / Stroke	Yes / No Difficulty Breathing	Yes / No Heart Disorder/Murmur/Defects	Yes / No Hepatitis or Liver Disorder
Yes / No Anemia / Bleeding Disorders	Yes / No Emphysema	Yes / No Artificial valves	Yes / No Kidney or Bladder Disorder
Yes / No Prolonged Bleeding/Clotting Disorder	Yes / No Asthma	Yes / No Hypertension	Yes / No Ulcers / Colitis
Yes / No Bone Problem or Disorder	Yes / No Bronchitis	Yes / No Congenital Heart Disease	Yes / No Pacemaker
Yes / No Arthritis/Joint Swelling	Yes / No Tuberculosis	Yes / No Heart Surgery	Yes / No Emotional Disorders
Yes / No Artificial Joints	Yes / No Neurologic Disorder	Yes / No Rheumatic Fever	Yes / No Hearing difficulties
Yes / No AIDS or HIV	Yes / No Cerebral Palsy	Yes / No Pacemaker	Yes / No Drug/Alcohol Abuse
Yes / No Fever Blisters	Yes / No Convulsions/Seizures	Yes / No Mitral Valve Prolapse	Yes / No Daily Aspirin / Blood Thinner
Yes / No Cancer / Chemotherapy / Radiation	Yes / No Headaches	Yes / No Endocrine/Hormone Disorders	Yes / No Pregnant (For women)
Yes / No Sinus Problems	Yes / No Glaucoma	Yes / No Diabetes	_____ **Doctor's Initials**

If you are experiencing or have a history of any disease, condition, or problem not addressed, please explain:

_____

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 in my medical status. I authorize the dental staff to perform with my informed consent, any necessary dental services I may need during diagnosis and treatment.

Signature: _____ **Date**: _____