morris DENTAL care
Healthy Teeth & Gums for Life

Welcome

We look forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.

ABOUT YOU

Today's date: _____

Name: _____

I like to be called: _____

Social security # _____

Home address: _____

_____

Employer: _____

Occupation: _____ Date of birth: _____

Whom may we thank for referring you? _____

_____

Marital status: ☐Single ☐Married ☐ Divorced ☐Widow

Spouses name: _____

Special interests or hobbies: _____

Email Address _____

Driver's License Number _____

Method of payment: ☐ Insurance ☐ Credit Card ☐ Cash

TELEPHONE INFORMATION

Home phone: _____

Work phone: _____

Cell phone: _____

What is the best time to call you? _____

And where? _____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY

Name: _____

Phone number: _____

DENTAL INSURANCE 1ST COVERAGE

Employee name: _____

Employee date of birth: _____

Employer: _____ # of Years _____

Name of Insurance Co. _____

Address: _____

_____

Telephone: _____

Group or Policy #: _____

Social security #: _____

DENTAL INSURANCE 2ND COVERAGE

Employee name: _____

Employee date of birth: _____

Employer: _____ # of Years _____

Name of Insurance Co. _____

Address: _____

_____

Telephone: _____

Group or Policy #: _____

Social security #: _____

RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for the purpose of evaluating and administering claims for insurance benefits.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims and insurance benefits.
I authorize release of any information concerning my (my child's) health care, advice and treatment to other dentist.
I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agrees to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

Patient's or Guardian Signature _____

Date: _____

REGISTRATION

DENTAL HISTORY

Why have you come to the dentist today? _____

_____

_____

Many patients consult us for a second opinion. Have you seen another dentist for your dental needs? _____

☐ Good ☐ Fair ☐ Poor

Are you currently in pain or discomfort with your teeth and gums? ☐ Yes ☐ No, If yes please explain:

_____

_____

The date of your last dental visit: _____

Previous dentist's name: _____

If you could wave a magic wand, and change anything you could about the appearance of your smile, what would you do?

_____

_____

_____

If you could easily and safely whiten your teeth, would you be interested? ☐ Yes ☐ No

How often do you brush your teeth? _____

Floss your teeth? _____

Do your gums bleed when you:

Brush? ☐ Yes ☐ No Floss? ☐ Yes ☐ No

Have you ever experienced pain in your jaw joint?

☐ Yes ☐ No

Do you grind your teeth? ☐ Yes ☐ No

Have you ever been treated for TMJ symptoms?

☐ Yes ☐ No, if yes please explain: _____

_____

_____

MEDICAL HISTORY

Name of personal physician: _____

Phone # _____

Last visit with physician: _____

Current health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you smoke or use chewing tobacco? ☐ Yes ☐ No

If yes how much per day? _____

Are you currently taking any prescription medication?

☐ Yes ☐ No, If yes please list below

Name of medication _____

Purpose _____

_____

_____

For women: Are you pregnant? ☐ Yes ☐ No

If yes how many months: _____

Do you plan on becoming pregnant in the near future and when? _____

Have you had any serious medical problems within the past 5 years? ☐ Yes ☐ No, if yes please explain: _____

_____

Have you ever had or been treated for any of the following diseases or medical problems?

Y N Heart attack/stroke
Y N Hepatitis/Jaundice
Y N Epilepsy/Seizures/ Fainting
Y N Cancer/Chemotherapy
Y N Psychiatric Problems
Y N Pacemaker or artificial Heart valve
Y N High/Low Blood Pressure
Y N Arthritis/Rheumatism
Y N Artificial joints/ Prosthesis
Y N Rheumatic fever
Y N Tuberculosis
Y N Drug/Alcohol abuse
Y N AIDS/HIV
Y N Heart murmur
Y N Diabetes
Y N Anemia
Y N Asthma

Have you been treated for any other illnesses not listed above?

☐ Yes ☐ No, if yes explain: _____

_____

_____

Do you need to be pre-medicated before dental treatment?

☐ Yes ☐ No ☐ Don't know

Are you allergic to any of the following medications?

Y N Penicillin
Y N Erthromycin
Y N Dental Anesthetic
Y N Latex
Y N Aspirin
Y N Codeine
Y N Metals

Are you allergic to any other medications? ☐ Yes ☐ No, if yes, please explain: _____

ANEST.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient's/ Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____

MED. ALERT

DENTAL/MEDICAL HISTORY