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

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Patient's Name _____
Last First Initial Nickname Date of Birth

Parent's/Guardian's Name _____

Comments

Dental History – Circle the appropriate answer

Is this your first visit to a dentist? YES NO
If not, how long since the last visit to the dentist? ___
Were any x-rays or radiographs taken when your child previously visited the dentist? YES NO
Does your child eat between meals? YES NO
Does your child eat sweets, such as candy, soda pop, chewing gum? YES NO
When does your child brush his/her teeth?
☐ Upon arising ☐ After eating any food ☐ Right after meals ☐ Before going to bed
How does your child receive Fluoride?
☐ Community water level _____ppm ☐ Well water level _ppm
☐ Fluoride drops or tablets ☐ Fluoride rinse or gel
Have any cavities been noted in the past? YES NO
Were any teeth (baby or permanent) removed by extraction? YES NO
Was it suggested that the space be maintained? YES NO
Was an appliance placed? YES NO
Have there been any injuries to teeth, such as falls, blows, chips, etc? YES NO
If so describe _____
Has your child had any problem with dental treatment in the past? YES NO
Has anyone in the family, including parents, had orthodontics? YES NO
Has your child ever received a local anesthetic? YES NO
Has your child ever had occlusal sealants? YES NO
Does your child think there is anything wrong with his/her teeth? YES NO

Medical History

Does your child have a health problem? YES NO
Is your child under care of physician? YES NO
If yes, since when and why? _____
Name of physician: _____ Phone: _____
Is your child receiving any medication? YES NO
What? _____
Is your child allergic to penicillin, antibiotics or other drugs? YES NO
Is your child allergic to or sensitive to any metals or latex? YES NO
Does your child have other allergies? YES NO
Has your child had any serious illness? YES NO
When? _____ What? _____
Has your child ever had surgery? YES NO
Does your child have a heart murmur? YES NO
Is surgery contemplated? YES NO
Does your child experience severe or prolongated bleeding? YES NO
Does your child have AIDS or has he/she tested HIV positive? YES NO
Has your child tested positive for hepatitis? YES NO
Is your child subject to nervous disorders? YES NO
☐ Fainting? ☐ Seizures? ☐ Dizziness? ☐ Behavioral/Learning problems?
Does your child have frequent headaches? YES NO
Has your child had a history of: (circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED.ALERT

CHILD DENTAL AND MEDICAL HISTORY