MABRY, AKHRASS & MCCARY, DDS

PATIENT INFORMATION

Name: _____
(First) (Middle Initial) (Last)

Home Number :_____ **Work Number:**_____ **Cell Phone:**_____

Soc. Sec #:_____ Birthdate: _____ Sex: M____ F_____

Single _____ Married_____ Widowed _____ Divorced _____

Address:_____ City :_____State:_____ Zip_____

E-Mail _____ Employer _____Occupation_____

Confirm my appointments by: (choose one) _____ text message _____ email _____ phone call

Parent's Name (if child) _____ Phone:_____ Employed By:_____

Spouse's/Name:_____ Phone:_____ Employed By:_____

Business Address:_____ Business Phone: _____Ext:_____

How did you hear about our office?_____ Reason for visit:_____

DENTAL INSURANCE

Insured Name :_____

Home Phone:_____ Work Phone:_____Cell Phone/Beeper _____

Relation to Patient:_____ Birthdate:_____ Soc. Sec # _____

Address (IF DIFFERENT THAN PATIENT'S)_____

Insured Employed By:_____ Occupation _____

Dental Insurance Company:_____

Subscriber I.D.#:_____ Group #:_____

ADDITIONAL INSURANCE

Is patient covered by another Dental Insurance plan: Yes ___ No __

Subscriber Name:_____ Relationship to Patient_____ Birthdate_____

Soc. Sec #_____ Home Phone_____ Work Phone_____ Cell Phone_____

Address (IF DIFFERENT THAN PATIENT'S)_____

Dental Insurance Company:_____ Subscriber I.D.#_____ Group #_____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for dental services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pending of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original)

SIGNATURE PATIENT OR LEGAL GUARDIAN:_____ **DATE:**_____

DENTAL HEALTH HISTORY

PATIENT'S NAME: _____
LAST FIRST MIDDLE INITIAL

Reason for today's visit:_____

Former Dentist:_____ Reason for Leaving:_____ Date of last dental care_____ Last dental x-rays_____

Check ( ) if you have had problems with any of the following:

____Bad breath
____Bleeding gums
____Clicking or popping jaw
____Food collection between teeth
____ Chipped or broken teeth
____ Grinding teeth
____ Loose teeth or broken fillings
____ Periodontal treatment
____ Sensitivity to cold
____ Sensitivity to hot
____ Sensitivity to sweets
____ Sensitivity when biting
____ Sores or growths in mouth

How often do you floss? _____ How often do you brush? _____ Do you smoke?_____
Do you take any herbs?_____ Name the herbs you take _____
Have you had any side effects from herbs?_____ Explain_____

Our office, **upon recommendation of the American Dental Association**, applies Topical Fluoride **every 6 months** to aid in the prevention of tooth decay**, through the age of 12 years**. **Most dental insurance companies will cover this procedure once a year**. Please check one box and sign:

____ **Yes**, I understand and give my consent to the application of Fluoride **every 6 months**.
____ **No**, I refuse the application of Fluoride every 6 months as recommended by the American Dental Association.

MEDICAL HISTORY

Physician's name_____ Date of last visit_____

Have you had any serious illnesses or operations? _____ Describe_____

Have you ever had a blood transfusion? Yes____ No____ if yes, give approximate date_____

Has your Physician ever told you that you need to take Antibiotics (Pre-Med) prior to having any dental work done due to recent joint replacement, heart surgery, etc. Yes_____ No_____

(Women) Are you pregnant Yes____ No____ Nursing? Yes___ No___ taking birth control pills? Yes____ No____

Check ( ) if you have had any of the following:

____ AIDS
____ Anemia
____ Arthritis, Rheumatism
____ HIV positive
____ Jaw pain
____ **Artificial Joints**
____ Asthma
____ Back Problems
____ Blood Disease
____ Cancer
____ Chemical Dependency
____ Chemotherapy
____ Circulatory Problems
____ Cortisone Treatments
____ Cough, Persistent
____ Cough up blood
____ Diabetes
____ Skin rash
____ Epilepsy
____ Fainting
____ Glaucoma
____ Headaches
____ Heart Murmur
____ Heart Problems
Describe:_____
____ **Hemophilia/Excessive Bleeding**
____ Hepatitis
____ High blood pressure
____ High Cholesterol
____ **Artificial Heart Valves**
____Migraines
____ Kidney disease
____ Liver disease
____ Mitral Valve Prolapse
____ Nervous Problems
____ Pacemaker
____ Psychiatric Care
____ Radiation Treatment
____ Respiratory Disease
____ **Sleep Apnea**
____ Rheumatic Fever
____ Scarlet Fever
____ ADD/ADHD
____ Seizures
____ Reflux
____ Stroke
____ Swelling feet/ankles
____ Thyroid problems
____ Tobacco habit
____ Tonsillitis
____ **Tuberculosis**
____ Ulcer
____ Venereal disease

MEDICATIONS

List medications you are taking:_____
_____
_____
_____

ALLERGIES

____ Aspirin
____ Barbiturates (Sleeping Pills)
____ Codeine
____ Local anesthetic
____ **Latex**
____ Penicillin
____ Sulfa drugs
____ Other_____
_____

The above information is complete and accurate to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

DATE:_____ **SIGNATURE:**_____