

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)

Your dental care is very important to us and we urge you to keep scheduled appointments. If you must cancel we require a 24 hour notice. Failure to comply with this will result in a charge of \$25.00 added to your account.

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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in mouth |
| <input type="checkbox"/> Chipped or broken teeth | | |

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:

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

MEDICATIONS

List medications you are taking: _____

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Barbiturates (Sleeping Pills)	<input type="checkbox"/> Sulfa drugs
<input type="checkbox"/> Codeine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Local anesthetic	_____
<input type="checkbox"/> Latex	

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: _____