Mapledale Family Dentistry

general dentistry • periodontics • orthodontics • cosmetic dentistry

Patient Information

Date _____ Social Sec. # _____ Birthdate_____

Name _____ Home Phone_____
Last Name First Name Initial

Address _____ Cell Phone_____

City_____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer_____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone_____

Dental History

Former Dentist _____ Date of Last X-Rays _____

City, State_____ How often do you floss? _____

Date of last dental visit? _____ How often do you brush? _____

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips of Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Bleeding ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Periodontal Treatment ☐
- Sensitivity to Cold/Hot ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

Medical History

Physician's Name_____ Date of Last Visit_____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐

Please describe_____

_____

_____

_____

	Yes	No
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐

6. Have you had any allergic reactions to the following:

	Yes	No		Yes	No
Local Anesthetics (eg. Novocaine)	☐	☐	Sedatives	☐	☐
Penicillin or other Antibiotics	☐	☐	Iodine	☐	☐
Sulfa Drugs	☐	☐	Aspirin	☐	☐
Barbiturates (sleeping pills)	☐	☐	Other	☐	☐

7. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough – persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis – Type ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Latex Sensitivity ☐
- Kidney Disease ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth ☐
- Ulcer ☐
- Venereal Disease ☐

Assignment & Release

I hereby authorize payment directly to Mapledale Family Dentistry for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____