MURPHY DENTAL HOME

PATIENT INFORMATION

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PATIENT OR PARENT'S EMPLOYER _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP _____

IF PT IS A STUDENT, NAME OF SCHOOL _____

CITY _____ STATE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

_____

CONFIDENTIAL

BIRTHDATE _____

HOME PHONE _____

CIRCLE APPROPRIATE SELECTION:

MINOR SINGLE MARRIED

DIVORCED WIDOWED SEPARATED

WORK PHONE _____

CELL PHONE _____

OTHER _____

EMAIL _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

_____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____

HOME PHONE _____

WORK PHONE _____

CELL PHONE _____

BIRTHDATE _____

SS NUMBER _____

INSURANCE INFORMATION

NAME OF INSURED _____

INSURANCE COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____

BIRTHDATE _____

SS NUMBER _____

GROUP NUMBER

_____

INSURANCE PHONE _____

ADDITIONAL INSURANCE

NAME OF INSURED _____

INSURANCE COMPANY _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

RELATIONSHIP TO PATIENT _____

BIRTHDATE _____

SS NUMBER _____

GROUP NUMBER_____

INSURANCE PHONE _____

PATIENT MEDICAL HISTORY

PHYSICIAN NAME _____

PHYSICIAN PHONE _____

- **ARE YOU UNDER THE CARE OF A PHYSICIAN** **YES** **NO**
- **HAVE YOU BEEN HOSPITALIZED IN THE LAST FIVE YEARS** **YES** **NO**
- **ARE YOU TAKING MEDICATIONS? INCLUDING OVER THE COUNTER AND PRESCRIPTION.** **YES** **NO**
- **DO YOU USE TOBACCO?** **YES** **NO**
- **DO YOU USE ALCOHOL?** **YES** **NO**
- **DO YOU USE COCAINE OR OTHER DRUGS?** **YES** **NO**
- **DO YOU WEAR CONTACTS?** **YES** **NO**
- **DO YOU HAVE ANY ALLERGIES?** **YES** **NO**

  _____

  _____
- **HAVE YOU EVER HAD A REACTION TO ANESTHETIC?** **YES** **NO**

EXPLAIN ABOVE: _____

_____

_____

DATE OF LAST EXAM _____

WOMEN ONLY:

- **ARE YOU PREGNANT** _____
- **ARE YOU NURSING** _____
- **ARE YOU TAKING BIRTH CONTROL PILLS** _____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS ABOUT YOURSELF:

(***MARK ALL ANSWERS WITH A YES OR NO)***

	YES	NO		YES	NO		YES	NO
HIGH BLOOD PRESSURE	___	___	**FREQUENTLY TIRED**	___	___	**KIDNEY DISEASE**	___	___
HEART ATTACK	___	___	**ANEMIA**	___	___	**AIDS/HIV INFECTION**	___	___
RHEUMATIC FEVER	___	___	**EMPHYSEMA**	___	___	**STD'S**	___	___
SWOLLEN ANKLES	___	___	**CANCER**	___	___	**THYROID PROBLEMS**	___	___
FAINTING/SEIZURES	___	___	**ARTHRITIS**	___	___	**HEPATITIS A, B OR C**	___	___
ASTHMA	___	___	**JOINT REPLACEMENT**	___	___	**ULCERS**	___	___
LOW BLOOD PRESSURE	___	___	**CHEST PAINS**	___	___	**RESPIRATORY PROBLEMS**	___	___
EPILEPSY/CONVULSIONS	___	___	**SHORT OF BREATH**	___	___	**OTHER** _____		
LEUKEMIA	___	___	**STROKE**	___	___	_____		
DIABETES	___	___	**HAY FEVER/ALLERGIES**	___	___	_____		
HEART DISEASE	___	___	**TUBERCULOSIS**	___	___	_____		
CARDIAC PACE MAKER	___	___	**RADIATION THERAPY**	___	___	_____		
HEART MURMER	___	___	**GLAUCOMA**	___	___	_____		
ANGINA	___	___	**LIVER DISEASE**	___	___			

PATIENT NAME _____ **PAGE 3**

PATIENT DENTAL HISTORY

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	1_____
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	2_____
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	3_____
4. DO YOU FEEL PAIN IN ANY OF YOUR TEETH?	4_____
5. DO YOU HAVE ANY SORES OR LUMPS IN YOUR MOUTH?	5_____
6. HAVE YOU EVER SUFFERED TRAUMA TO YOUR FACE MOUTH OR JAW?	6_____
7. DOES YOUR JAW EVER CLICK, POP, CRACKLE OR ACHE?	7_____
8. DO YOU HAVE PAIN IN YOUR JAW JOINT, EAR OR SIDE OF THE FACE?	8_____
9. DO YOU HAVE DIFFICULTY OPENING OR CLOSING YOUR MOUTH?	9_____
10. DO YOU HAVE DIFFICULTY CHEWING?	10_____
11. DO YOU HAVE FREQUENT HEADACHES?	11_____
12. DO YOU CLENCH OR GRIND YOUR TEETH?	12_____
13. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	13_____
14. DO YOU, OR A FAMILY MEMBER, DO ANY OF THE FOLLOWING: SNORE? CHOKE OR GASP FOR AIR WHILE SLEEPING? WAKE FREQUENTLY AT NIGHT? FEEL TIRED OR FATIGUED THROUGH THE DAY? HAVE HAD A SLEEP STUDY OR HAVE A CPAP?	14 Snore?_____Choke?_____ 14 Wake Frequently?_____ 14 Feel Tired?_____ 14 Sleep Study?_____CPAP?_____
15. HAVE YOU HAD PROBLEMS WITH PREVIOUS DENTAL WORK?	15_____
16. HAVE YOU EVER HAD BRACES?	16_____
17. HOW MANY TIMES A DAY DO YOU BRUSH YOUR TEETH?	17_____
18. HOW OFTEN DO YOU FLOSS?	18_____
19. DO YOU USE A MANUAL BRUSH OR ELECTRIC?	19_____
20. DO YOU USE ANY TYPE OF MOUTH RINSE?	20_____

GOALS FOR YOUR MOUTH, TEETH AND SMILE: _____

_____

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD THAT BE? _____

_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

_____ _____
PATIENT SIGNATURE DATE

_____
PRINT NAME

_____
DENTIST SIGNATURE

_____
DATE

_____
WITNESS SIGNATURE

_____
DATE