



Med. Alert _____ Pre-Med _____ Allergies _____ DATE: _____

PATIENT INFORMATION

Name _____ Birthdate _____

Telephone _____ Work # _____ Cell phone # _____

Address _____ City _____ State _____ Zip Code _____

Employer _____ Spouse's Name _____

Soc. Sec. Number _____ E-mail Address _____

Emergency Contact _____ Relationship _____ Emergency Phone _____

If patient is a minor, who is legally responsible? Please list the name, complete address and phone number:

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Name of primary insurance _____ Group# _____ Employer _____

Insurance Address _____ Phone # _____

Employee/Subscriber _____ SSN# _____ Birthdate _____

Relationship to Employee _____ Full-time student? _____ Name of School _____ City _____

Is the patient covered by a secondary dental plan? _____ Name of Carrier _____ Group # _____

Insurance Address _____ Phone # _____

Employee/Subscriber _____ SSN# _____ Birthdate _____

Employer _____ Relationship to employee _____

A service charge of 1-1/2% per month (18% annual rate) will be applied to balances over 90 days, \$1.00 minimum charge.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the insurance claim. If the patient is a minor, permission is granted for dental treatment, as deemed necessary to be performed in our office or until written notice is given discounting this permission.

Signature required _____ Date _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. Stacy J. Moon.

Signature required _____ Date _____

Your answers are for our records only and will be kept confidential in accordance with applicable laws.

Dental Information

What is your chief complaint? _____

Are you happy with your teeth and their appearance? _____ If not, what would you like to see different? _____

Date of your last dental visit: _____ Date of last dental x-rays: _____

Yes No Don't Know

- Do your gums bleed when you brush?
- Are your teeth sensitive to cold/hot, sweets or pressure?
- Do you have headaches, earaches, or neck pain?
- Have you ever had a bad reaction to dental anesthetic?
- Does food catch between your teeth?
- Have your teeth ever been bleached?

Yes No Don't Know

- Have you ever had orthodontic treatment?
- Have you ever had periodontal treatment?
- Do you wear removable dental appliances?
- Have you ever been told you grind your teeth?
- Are you aware of your jaw clicking or popping?
- Do you have dental implants?

Medical Information

Physician name _____ Date of last visit _____ Condition treated _____

Yes No Don't Know

- Are you taking any medications including non-prescription medications? If so what are you taking? _____
- Are you in good health? If any changes in your general health within the past year please describe: _____
- Are you taking, or have you taken any diet drugs? (Pondimin, Redux, or Phen-fen)
- Do you use tobacco (smoking, snuff, chew)? Frequency and amount: _____
- Do you wear contact lenses?
- Are you pregnant? Due date: _____ Nursing? _____ Birth Control Pills? _____
- Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when _____

Allergies:

Yes No Don't Know

- Local anesthetics
- Aspirin
- Penicillin or other antibiotics _____
- Barbiturates, sedatives or sleeping pills _____
- Sulfa drugs

Yes No Don't Know

- Latex
- Iodine
- Hay Fever / Seasonal
- Animals
- Codeine or other narcotics _____

To yes responses, specify type and reaction _____

Please (x) if you have or had any of the following diseases or problems.

Yes	No	Don't Know	Yes	No	Don't Know	Yes	No	Don't Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Bleeding			Chronic pain			Neurological disorders		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify:		
AIDS or HIV infection			Persistent diarrhea			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis		
Anemia			Disease, drug or radiation- Induced immunosuppression			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problems		
Arthritis			Diabetes -specify type o Type I (insulin dep) o Type II			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema o Bronchitis, etc.		
Rheumatoid arthritis			Dry Mouth			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches		
Asthma			Eating disorder			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify type:			Severe or rapid weight loss		
Blood transfusion			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer / chemo / radiation			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease			G.E. Reflux			Sleep disorder		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sores or ulcers in the mouth		
o Angina			Glaucoma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia			Stroke		
o Arteriosclerosis			Hepatitis/jaundice/liver disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent infections			Systemic lupus erythematosus		
o Artificial heart valves			If yes, specify type:			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems			Thyroid problems		
Date:			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure			Ulcers		
o Coronary insufficiency			Mental health disorders			Excessive Urination		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify type:			Do you have any disease		
o Coronary occlusion			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify:		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition					
o Damaged heart valves			Migranes					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats					
o Heart Attack								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
o Heart Murmur								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
o High blood pressure								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
o Inborn heart defects								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
o Mitral valve prolapse								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
o Pacemaker								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
o Rheumatic heart disease								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Chest pain upon exertion								

I certify that I have read and understand the above. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient / Legal Guardian

Date