

Dennis R. Mooney, D.D.S. Dental Registration & Health History

To receive treatment in this office you must answer ALL questions on this history form. If you have any questions or need assistance, please ask the receptionist and we will be happy to help!

PATIENT INFORMATION (CONFIDENTIAL)



Name _____
First Middle Initial Last

Address _____
City State Zip

Home Phone _____ Business Phone _____ ext _____

Cell Phone/Pager _____ Other Phone _____

Sex: Male Female Single Married Widowed Separated Divorced Child

If Child, Full Name of Custodial Parent (Please Print) _____

Patient or Responsible Party's Occupation _____

PATIENT CONTACT DATA



Person Responsible for this Account _____ Relationship _____
To Patient

Responsible Party's Employer _____ Responsible Party's Work or Cell Phone _____

Person to Contact in Case of Emergency _____ Relationship _____
To Patient

EMAIL Address _____

Contact's Home Phone _____ Contact's Work Phone _____ Contact's Cell Phone _____

Alternate contact if we cannot reach you _____ Phone _____

PATIENT ESSENTIALS



Date of Birth _____

Social Security # _____

Driver's License # _____

Financial Institution _____

Medicaid # (if applicable) _____

Who May We Thank for Referring You To Our Office?

Do you have an Immediate Family Member that is currently a patient in our Office? Yes No

If Yes, their name _____

DENTAL INSURANCE INFORMATION



Insurance Company _____

Group # _____ Certificate # _____

Name of Subscriber _____

Relationship of Subscriber to Patient _____

Subscriber's Social Security # _____

Subscriber's Date of Birth _____

Have you seen a dentist within 6 months? Yes No

Is patient covered by additional insurance? Yes No

Is patient covered by Medicaid/Medipass? Yes No

Is patient covered by Healthy Kids? Yes No

How much is Your deductible? _____ How much have You used? _____

How much is your Max. Annual Benefit? _____ How much have You used? _____

TRUTHFUL ACKNOWLEDGEMENT • PERMISSION TO RELEASE INFORMATION • ASSIGNMENT OF BENEFITS

I, the undersigned certify that any and all information provided for myself (or my dependent) is truthful and accurate to the best of my knowledge. NOTE: A change in your health should be reported to the office immediately. I grant the right to the dentist or proxy to release health information obtained from me, and information about my dental treatment to third party payers and/or health practitioners. I consent to the use of Web Enable for email notifications and additional correspondence. I, the undersigned, assign directly to Dr. Mooney all insurance benefits, if any, otherwise payable to me for services rendered. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be financially responsible for payment for all charges of any services rendered on my behalf or my dependents whether or not paid by Insurance, as well as any collection fees which may be incurred due to nonpayment. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I also understand that failure to provide 24 hours notice on any missed appointments may result in either the application of a fee of \$50 or dismissal from this practice, when appropriate.

Signature of Responsible Party: _____ Date: _____

Look at back side

ALLERGIES

Please check if you are allergic to, or if you have had any reactions to any of the following:



- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetics / Novocain |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Latex Rubber | <input type="checkbox"/> Metals (nickel, mercury, etc) |

Other (List & Explain):

MEDICATIONS

Are you taking medications (including non-prescription medicine)? Yes No List below:



- Do you use Tobacco? Yes No
- Do you use controlled substances? Yes No

PATIENT MEDICAL HISTORY

Please note: providing incorrect information can be dangerous to Your health.



Your Physician's Name _____ City, State _____ Phone _____

Do you have or have you had any of the following?

| | | | | | | | |
|---------------------------|--|---------------------|--|---------------------|--|-------------------|--|
| AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Contact Lenses | <input type="checkbox"/> Yes <input type="checkbox"/> No | STD | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Easily Winded | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chest Pains | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Leukemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cough/Persistent | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are You Pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | VD | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cardiac Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis/Type___ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependent | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequently Tired | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dental Phobias? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

PATIENT DENTAL HISTORY



Name of Previous Dentist and Location:

Date of your last Dental visit: _____ Date of your last Cleaning: _____

| | | | |
|---------------------------------|--|---------------------------------------|--|
| Bad Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficult extractions in past? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Gums | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prolonged Bleeding after extractions? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Clicking or Popping Jaw | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had Orthodontic Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Teeth sensitive to Hot/Cold | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you wear dentures/partials | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Teeth sensitive to Sweet/Sour | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you Like your smile? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sores or Blisters in/near Mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you bite lips/cheeks? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Head/Neck/Jaw Injuries | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you Clench/Grind teeth? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have frequent Headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have a Dry Mouth? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Would you like to discuss or view a short film on any of the following:

| | | | |
|--|--|--|--|
| "Invisalign" the Clear Solution to a beautiful Smile | <input type="checkbox"/> Yes <input type="checkbox"/> No | "Silent Night" Snore Prevention | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| "Playsafe" Dentist-Fitted Sports MouthGuards | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prescription Dose Whitening/Bleaching Products | <input type="checkbox"/> Yes <input type="checkbox"/> No |

