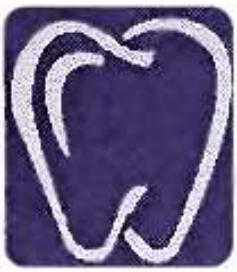
Dennis R. Mooney, D.D.S. ◙ Dental Registration & Health History

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_____ Email Address _____

Sex: ☐Male ☐Female Status: ☐Dependent Child ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

If Child, Full Name of Custodial Parent(s) (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_____
Responsible Party's Email Address_____

Person to Contact in Case of Emergency_____ Relationship To Patient _____
Emer. Contact's Home Phone_____ Emer. Contact's Work Phone_____ Emer. Contact's Cell Phone_____

Alternate Authorized Guardians _____

PATIENT ESSENTIALS

Date of Birth_____

Social Security #_____

Driver's License#_____

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_____

Employer Name_____

Group #_____ Identification or 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

Have you used this coverage plan prior to today? ☐ Yes ☐ No

Is patient covered by additional insurance? ☐ Yes ☐ No

If Yes, Name of Plan _____

Is patient covered by Medicaid/Medipass? ☐ Yes ☐ No

Is patient covered by Healthy Kids? ☐ Yes ☐ No

How much is Your Plan Deductible? _____

How much is your Maximum Annual Benefit? _____

TRUTHFUL ACKNOWLEDGEMENT • PERMISSION TO RELEASE INFORMATION • ASSIGNMENT OF BENEFITS

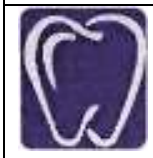
I, the undersigned certify that any and all information provided for myself (or my dependent) is truthful and accurate to the best of my knowledge. NOTE: A change in your health should be reported to the office immediately. I grant the right to the dentist or proxy to release health information obtained from me, and information about my dental treatment to third party payers and/or health practitioners. I consent to the use of SolutionReach 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:_____

Please fill out backside of Form

ALLERGIES

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



☐ Aspirin	☐ Local Anesthetics / Novocain
☐ Barbiturates	☐ Penicillin
☐ Codeine	☐ Sulfa Drugs
☐ Iodine	☐ Sedatives
☐ Latex Rubber	☐ 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	Do you use Alcohol? ☐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?

ADD / ADHD	☐Yes ☐No	Chemical Dependent	☐Yes ☐No	Glaucoma	☐Yes ☐No	Liver Disease	☐Yes ☐No
AIDS	☐Yes ☐No	Chemotherapy	☐Yes ☐No	Hay Fever	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No
Anemia	☐Yes ☐No	Chest Pains	☐Yes ☐No	Headaches	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No
Angina	☐Yes ☐No	Congenital Heart Problems	☐Yes ☐No	Heart Attack	☐Yes ☐No	Pregnant - Currently	☐Yes ☐No
Arthritis	☐Yes ☐No	COPD / Respiratory Trouble	☐Yes ☐No	Heart Disease	☐Yes ☐No	Radiation Treatment	☐Yes ☐No
Artificial Joints	☐Yes ☐No	CPAP Device	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Asthma	☐Yes ☐No	Dental Phobia	☐Yes ☐No	Hepatitis/Type___	☐Yes ☐No	STD / VD / Herpes	☐Yes ☐No
Autism	☐Yes ☐No	Depression	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Stroke	☐Yes ☐No
Arrhythmia / Afib	☐Yes ☐No	Diabetes	☐Yes ☐No	HIV	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Blood Clots / Embolism	☐Yes ☐No	Emphysema	☐Yes ☐No	Jaundice	☐Yes ☐No	Transplant	☐Yes ☐No
Cancer	☐Yes ☐No	Epilepsy	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Cardiac Pacemaker	☐Yes ☐No	Fainting	☐Yes ☐No	Leukemia	☐Yes ☐No	Ulcers	☐Yes ☐No

If you answered "YES" to any of the above, please give Details if necessary:

List any Surgeries & Occurrence Dates:

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location:

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

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

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

"Invisalign" the Clear Solution to a beautiful Smile	□Yes □No	"Silent Night" Snore Prevention	□Yes □No
"Playsafe" Dentist-Fitted Sports MouthGuards	□Yes □No	Prescription Dose Whitening/Bleaching Products	□Yes □No