Mahomet Family Dentistry

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us we will be happy to help.

Please Print.

Patient Information (Confidential)

Name: _____ Preferred to be called: _____
First Middle Last

Home # _____ Work # _____ Cell # _____

Address: _____ City: _____ State: _____ Zip: _____

Check appropriate Box: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated SS# _____

Sex: ☐ Male ☐ Female Birthdate: _____ Whom may we thank for referring you? _____

Name of Person to contact in case of an emergency: _____ Phone # _____

Responsible Party (If different from above)

Name of person responsible for this account: _____ Relationship to the patient _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone # _____ Home # _____ Cell # _____

Dental Insurance Information

Name of person insurance is under: _____
First Middle Last

Birthdate: _____ Relationship to patient: _____

Employer: _____ Address: _____ City: _____ State: _____ Zip: _____

Name of Insurance _____ Address: _____ City: _____ State: _____ Zip: _____

ID # _____ Social Security # _____ Union or Group # _____

Do you have additional dental insurance? ☐ Yes ☐ No (If yes please show us your card)

Financial Policy

Payment in full is due on the day of service unless:

You have an accepted group dental insurance policy in effect that will pay us directly. You are expected to pay any remaining portion within 30 days of the insurance payment or processing. For the convenience of our patients, we will file all claims from our office on the date of service.

OR

Comprehensive treatment is incurred requiring additional visits and /or laboratory expenses. 50% of the total cost must be paid on the day of service with the remaining balance due on the next dental visit.

We do not offer monthly payment plans, however we do offer Care Credit. If you are interested in this we would be happy to explain this option to you. However we do accept Master Card and Visa, credit or debit cards, checks, and/or cash.

Your cooperation with this policy will assure equitable treatment of all patients.

X _____
Signature of patient or responsible party **Date**

Patient Medical History

Patients name _____

Medical Doctor_____ Office Phone _____ Date of last exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you been hospitalized for any Surgical operation or serious illness With in the last 5 years?	☐	☐
If yes please explain why: _____		
3. Are you taking any medications?	☐	☐
Please List: _____		
4. Have you taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use a controlled substance? (E.g. Meth or Cocaine)	☐	☐
7. Are you a recovering substance abuser?	☐	☐
8. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
9. Are you wearing contact lenses?	☐	☐
10. Are allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metal (e.g. Nickel, Mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Sulfite Sensitivity	☐	☐
Other (Please List): _____		
11. Do you have a hard time waking up from general Anesthetic?	☐	☐
12. Do you have any special needs?	☐	☐
If yes please specify: _____		
13. Women Only:		
A) Are you pregnant or think you may be pregnant?	☐	☐
B) Are you nursing?	☐	☐
C) Are you taking oral contraceptives?	☐	☐

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

	Yes	No		Yes	No		Yes	No
Low/High Blood Pressure	☐	☐	Heart Murmur	☐	☐	Easily Winded	☐	☐
Heart Attack	☐	☐	Angina	☐	☐	Stroke	☐	☐
Rheumatic Fever	☐	☐	Frequently Tired	☐	☐	Hay Fever/Allergies	☐	☐
Swollen Ankles	☐	☐	Anemia	☐	☐	Tuberculosis (TB)	☐	☐
Fainting/Seizures	☐	☐	Emphysema	☐	☐	Radiation Therapy	☐	☐
Asthma	☐	☐	Cancer/Tumors	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Leukemia	☐	☐	Joint Replacement	☐	☐	Heart Trouble	☐	☐
Diabetes	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
Kidney Diseases	☐	☐	Organ Transplant	☐	☐	Mitral Valve Prolapse	☐	☐
AIDS or HIV Infections	☐	☐	Stomach Troubles/Ulcers	☐	☐	Sinus Problems	☐	☐
Thyroid Problems	☐	☐	Back Problems	☐	☐	Bleeding Problems	☐	☐
Heart Disease	☐	☐	Psychiatric Problems	☐	☐	Shingles	☐	☐
Cardiac Pacemaker	☐	☐	Chest Pain	☐	☐	Other_____		

Patient Dental History

Name of Previous Dentist: _____ Phone #: _____ Date of Last Dental X-rays: _____

	Yes	No		Yes	No
1. Do you require premedication before dental visit?	☐	☐	9. Do you have frequent headaches?	☐	☐
2. Do your gums bleed while brushing or flossing?	☐	☐	10. Do you clench or grind your teeth?	☐	☐
3. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐	11. Do you bite your lips or cheeks frequently?	☐	☐
4. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐	12. Have you ever had any difficult extractions?	☐	☐
5. Do you feel pain to any of your teeth?	☐	☐	13. Have you ever had any prolonged bleeding following extractions?	☐	☐
6. Do you have any sores or lumps in or near your mouth?	☐	☐	14. Have you had any orthodontic treatment?	☐	☐
7. Have you had any head, neck or jaw injuries?	☐	☐	15. Do you wear dentures or partials?	☐	☐
8. Have you ever experienced any of the following problems in your jaw?			If yes, date of placement? _____		
Clicking?	☐	☐	16. Have you ever received brushing instructions?	☐	☐
Pain (joint, ear, side of face)?	☐	☐	17. Have you ever received flossing instructions?	☐	☐
Difficulty in opening or closing?	☐	☐	18. Do you floss?	☐	☐
Difficulty with chewing?	☐	☐	19. Do you brush 2 times a day?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to the third party payers and /or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient or responsible party **Date**