

Magusiak & Morgan

We are complimented that you have selected us to provide dental care for you and your family.
Whom may we thank for referring you to our office? _____

Patient Information

Date ____/____/____	email: _____
Patient's Name _____ <small>Last First Middle</small>	Preferred Name _____ <input type="checkbox"/> Male <input type="checkbox"/> Female
Address _____ <small>Street City State Zip</small>	
Home Ph. (____) _____	Cell Ph. (____) _____ Soc. Sec. # ____-____-____ Birthdate ____/____/____
<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced If Patient is a minor, give parent's/guardian's name _____	
If patient is a full-time student, fill in school name _____	
Employer _____ (Phone #) _____	Occupation _____
Name of Nearest Relative not living with you _____	Relationship _____
Complete Address _____	Phone # (____) _____
Emergency Contact _____	Phone # (____) _____

Responsible Party Information (if other than patient)

Name _____
Social Security # ____-____-____ Birthdate ____/____/____ Relationship to Patient _____
Residence _____
Mailing Address _____
How long at this address _____ Home Ph.#(____) _____ Work Ph.#(____) _____
Previous Address (if less than 3 years) _____
Employer _____ Occupation _____ No. Years Employed _____
Employer Address _____

Spouse's Information

Spouse's Name _____
Social Security # ____-____-____ Birthdate ____/____/____ Work Ph.#(____) _____
Employer _____ Occupation _____ No. Years Employed _____
Employer Address _____

Insurance Information

Insured's Name _____ Birthdate ____/____/____ Insured's Social Security# ____-____-____
Insurance Company _____ Group No. _____
Insurance Company Address _____
*We do not accept secondary dental insurance.

Consent

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that any necessary collection charges may be added to my account.
4. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ Date ____/____/____

Parent or Responsible Party _____ Relationship to Patient _____

Dental / Medical History

Why have you come to the dentist today? _____

Are you currently in pain? Yes No

Do you require antibiotics before dental treatment? Yes No

Do you floss daily? Yes No Brush daily? Yes No

Would you like fresher breath? Yes No Whiter teeth? Yes No

Have you ever experienced/had:

Gums ever bleed or hurt? Yes No

Periodontal disease/treatment? Yes No

Mobility in your teeth? Yes No

Sensitivity to heat or cold? Yes No

Pain discomfort in your jaw joint? Yes No

Problems associated with previous dental work? Yes No

Have you ever experienced/had:

Orthodontic treatment? Yes No

Clicking or popping of the jaw? Yes No

Do you:

Clench or grind your teeth? Yes No

Mouth breathe? Yes No

Have tired jaws? Yes No

Use tobacco products? Yes No

Do you still have wisdom teeth? Yes No

Are you happy with the way your smile looks? Yes No

If not, what would you change? _____

Is there anything else about having dental treatment you would like to know? _____

- Are you or have you been under the care of a medical doctor during the past two years? Yes No
If yes, for what? _____
Physician's Name _____ Phone _____
- Are you taking any prescription/over the counter medications? Yes No
If yes, please list name and dosage _____
- Are you aware of having an allergic (or adverse reaction) to any of the following Medications?
 Penicillin Yes No Tetracycline Yes No Latex Yes No Erythromycin Yes No
 Aspirin Yes No Dental Anesthetics Yes No Other Yes No Codeine Yes No
 Please list any other drugs that you are allergic to: _____
- Have you been a patient in the hospital during the past 5 years? Yes No
- Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.**

Heart (Surgery, Disease, Attack) _____	Yes	No	Ulcers _____	Yes	No	Hepatitis A (infectious) B (serum) _____	Yes	No
Chest Pain _____	Yes	No	Diabetes _____	Yes	No	Venereal Disease _____	Yes	No
Congenital Heart Disease _____	Yes	No	Thyroid Problems _____	Yes	No	H.I.V. Positive (Aids) _____	Yes	No
Heart Murmur _____	Yes	No	Glaucoma _____	Yes	No	Cold Sores/Fever Blisters _____	Yes	No
High Blood Pressure _____	Yes	No	Emphysema _____	Yes	No	Blood Transfusion _____	Yes	No
Mitral Valve Prolapse _____	Yes	No	Chronic Cough _____	Yes	No	Hemophilia _____	Yes	No
Artificial Heart Valve _____	Yes	No	Tuberculosis _____	Yes	No	Sickle Cell Disease _____	Yes	No
Heart Pacemaker _____	Yes	No	Asthma _____	Yes	No	Liver Disease _____	Yes	No
Rheumatic Fever _____	Yes	No	Hay Fever _____	Yes	No	Neurological Disorders _____	Yes	No
Arthritis/Rheumatism _____	Yes	No	Latex Sensitivity _____	Yes	No	Epilepsy or Seizures _____	Yes	No
Cortisone Medicine _____	Yes	No	Allergies or Hives _____	Yes	No	Fainting or Dizzy Spells _____	Yes	No
Stroke _____	Yes	No	Sinus Trouble _____	Yes	No	Nervous/Anxious _____	Yes	No
Artificial Joints (hip, knee, etc.) _____	Yes	No	Radiation Therapy _____	Yes	No	Psychiatric/Psychological Care _____	Yes	No
Kidney Trouble _____	Yes	No	Chemotherapy _____	Yes	No	Tumors _____	Yes	No
Drug Addiction _____	Yes	No	Cancer _____	Yes	No			

- Do you have or have you had any disease, condition, or problem not listed?
If yes, please list: _____

Women only: Are you: Pregnant? Yes, _____ Months No Nursing? Yes No Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

Reviewed by Doctor _____ Date _____

History Review and Significant Findings: _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	REVIEWED
_____	_____	NONE <input type="checkbox"/>	DR. _____
_____	_____	NONE <input type="checkbox"/>	DR. _____
_____	_____	NONE <input type="checkbox"/>	DR. _____
_____	_____	NONE <input type="checkbox"/>	DR. _____
_____	_____	NONE <input type="checkbox"/>	DR. _____