Timothy J. O'Connor, D.D.S.

Welcome to our office! We appreciate your having selected us to care for your dental needs. It is our primary goal to provide quality dental care for you, and to do so as thoroughly and comfortably as possible.

During your first visit a thorough examination will be completed. This will include examining the condition of the teeth, their existing restorations and the health of gums and supporting bone. Also included will be a review of your medical and dental history and an oral cancer screening. Because a complete series of x-rays is one of the most essential diagnostic tools, time will be set aside to complete these as well. Any conditions needing attention will be explained, along with treatment alternatives, so that together we may decide how to ideally proceed with your care. Please anticipate being with us for approximately 1 and ½ hours to complete your exam and films.

Our front office staff will be happy to answer any questions you may have concerning financial arrangements, as well as providing you with assistance regarding insurance coverage.

Please choose one of the options below to complete the two new patient information forms.

Option 1: Print the Patient Information and Health History Forms, fill them out and bring them the day of your appointment.

Option 2: Download the Patient Information and Health History Forms, fill them out, scan them onto the computer and email them as an attachment to murphysdentist@att.net.

Again, we thank you and look forward to meeting you!

Dr. O'Connor and Staff

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www.timothyjoconnordds.com

WELCOME

PATIENT INFORMATION

Date ______ ID# / SS# ______

Patient ______

Street Address ______

P.O. Box ______

City/Zip ______

Sex: ☐ M ☐ F Age ______ Birthdate ______

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation ______

Employer ______

Employer Address ______

Employer Phone ( ) ______

Spouse's Name ______

Birthdate ______ SS# ______

Occupation ______

Spouse's Employer ______

______

DENTAL INSURANCE

Who is responsible for this account? ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's name ______

Birthdate ______ SS# ______

Relationship to patient ______

Insurance Co. ______

Group # ______

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ______ and assign directly to Dr. O'Connor all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. 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.

______
Responsible Party Signature

______
Relationship Date

PHONE NUMBERS

Cell ( ) ______ Email: ______

Home ( ) ______ Work ( ) ______ Ext ______ Spouse's Work ( ) ______

Best place to reach you ______

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ______ Relationship ______

Home Phone ( ) ______ Work Phone ( ) ______

Fees: We ask that payment be made at the time services are rendered unless arrangements are made with our front office in advance. We will be happy to file your dental insurance for you as a courtesy. However, responsibility for payment for your dental care rests ultimately with you.

Please initial ______

Broken appointments: Your appointment card shows the day and time you've reserved for your dental care. If you are unable to be here, no charge will be made provided we receive 48 HOURS NOTICE. In this way we may adjust our schedule accordingly. We appreciate your courtesy and understanding in this matter.

Please initial ______

We thank you very much for selecting our office. If at any time you have questions regarding any treatment, fee, or service, please feel free to discuss them with us promptly. We look forward to working together with you.

HEALTH HISTORY QUESTIONNAIRE

Patient's Name: ______________________ Birthdate/Age ______________

Whom may we thank for referring you to our office? ______________________

Are you allergic to any medications? Please list: ______________________

Are you allergic to any materials? Example: Metals, Latex... ______________________

Are you taking medications or drugs? Please list: ______________________

Do you take Bisphosphonates? Example: Fosamax, Actonel, Boniva .... Yes No

Have you seen a physician in the past 2 years? .... Yes No

Physician's name: ______________________

Physician's phone number: ______________________

Have you been hospitalized or had a serious illness in the past 5 years? .... Yes No

Please Explain: ______________________

Have you ever been told to be premedicated with an antibiotic before dental treatment? .... Yes No

Have you ever had joint replacement or heart valve replacement surgery? .... Yes No

Do you or have you even been told that you clench or grind your teeth? .... Yes No

Have you had problems with past dental treatment? .... Yes No

Please Explain: ______________________

Is there any other information you would like Dr. O'Connor to be aware of? .... Yes No

Please Explain: ______________________

Do you smoke? .... Yes No If so, how much? ______________ Do you use smokeless tobacco .... Yes No

Females: Are you pregnant? .... Yes No Are you taking birth control medication .... Yes No

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Do you have or have you ever had any of the following conditions or diseases?

Condition		
Abnormal Bleeding	Y	N
Acid Reflux	Y	N
Alcohol/Drug Abuse	Y	N
Anemia	Y	N
Angina	Y	N
Arthritis	Y	N
Artificial Joints	Y	N
Asthma	Y	N
Blood Transfusion	Y	N
Cancer / Chemotherapy	Y	N
Congenital Heart Defect	Y	N
Colitis	Y	N
Diabetes	Y	N
Difficulty Breathing	Y	N
Emphysema	Y	N

Condition		
Epilepsy / Seizure	Y	N
Fainting Spells	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Heart Attack	Y	N
Heart Murmur / MVP	Y	N
Heart Surgery	Y	N
Hemophilia	Y	N
Hepatitis	Y	N
Herpes / Fever Blisters	Y	N
High Blood Pressure	Y	N
HIV / AIDS	Y	N
Kidney Problems	Y	N
Liver Disease	Y	N
Low Blood Pressure	Y	N

Condition		
Lung Disease / TB	Y	N
Pacemaker	Y	N
Psychiatric Problems	Y	N
Radiation Treatment	Y	N
Replacement Valves	Y	N
Rheumatic Fever	Y	N
Rheumatic Heart Disorder	Y	N
Scarlet Fever	Y	N
Shingles	Y	N
Sickle Cell Disease	Y	N
Sinus Problems	Y	N
Stroke	Y	N
Thyroid Problems	Y	N
Ulcers / Stomach	Y	N
Venereal Disease	Y	N

Is there anything about your smile you would like to change?

- ☐ Whiter teeth
- ☐ Straighter teeth
- ☐ Close spaces
- ☐ Replace missing teeth
- ☐ Other ______________

I agree to take responsibility for updating this office of any changes in my health, medications, etc., that may occur.

I do hereby authorize and consent to any examination, x-ray, anesthetic, or dental treatment to be rendered under the general or direct supervision of Dr. Timothy J. O'Connor.

Signature of Patient, Parent or Guardian:

______________________ Date ______________

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