MaxMolgard
PROSTHODONTICS ESTHETICS

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PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date_____

If minor, parents names _____ Home # _____ Work # _____

Preferred contact method: ❑ Cell ❑ Work ❑ Home ❑ E-mail Cell # _____ E-mail _____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

Whom may we thank for referring you to our office? _____ ❑ Internet

Emergency Contact_____ Relationship_____Cell #_____Home #_____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following? (Please check any that apply)

- ❑ Cancer or tumor
- ❑ Radiation treatment
- ❑ Stroke
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Glaucoma
- ❑ Respiratory problems
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hay fever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma
- ❑ Stomach/ digestive or ulcer issues

Do you smoke, use chewing tobacco or e-cig? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine

Please list any other medications that you are currently taking:

_____

_____

_____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician:_____Date of last visit:_____

Do you have any disease, condition, or problem not listed above?_____

Signature of patient (or parent) _____ Date _____

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Dental History

Reason for today's visit:_____

Date of last dental care: _____ Date of last dental x-rays:_____

Do you have or have problems with any of the following? (Please check any that apply)

- ❑ Tooth pain
- ❑ Sensitivity to cold
- ❑ Sensitivity to heat
- ❑ Bleeding gums when brushing or flossing
- ❑ Clicking or popping jaw
- ❑ Food collecting between teeth
- ❑ Grinding teeth
- ❑ Sores or growths in your mouth
- ❑ Periodontal disease (bone loss)
- ❑ Loose teeth

Do you experience stress or anxiety when you visit a dental office?

Please circle from 1-10 your level of anxiety, with
1 = I am not anxious and 10 = I am extremely anxious

1 2 3 4 5 6 7 8 9 10

Are you pleased with the color of your teeth? ❑ yes ❑ no
Are you pleased with your smile? ❑ yes ❑ no
Are you pleased with the way your teeth function? ❑ yes ❑ no
Do you have removable dentures/partial dentures? ❑ yes ❑ no For how long? _____
How old is your current denture/partial denture?_____
Are you happy with your current denture/partial denture? ❑ yes ❑ no

Insurance Information

Primary Insurance: (Please present card to receptionist)

Insurance company:_____ Group #:_____

Subscriber's name:_____
Last First Middle

Subscriber's SS# or insurance ID _____ Subscriber's Date of Birth:_____

Patient's relationship to Subscriber: ❑ Self ❑ Spouse ❑ Dependent

Secondary Insurance: (Please present card to receptionist)

Insurance company:_____ Group #:_____

Subscriber's name:_____
Last First Middle

Subscriber's SS# or insurance ID _____ Subscriber's Date of Birth:_____

Patient's relationship to Subscriber: ❑ Self ❑ Spouse ❑ Dependent

Patient Responsibility and Release

I authorize payment to be made directly to the dentist by my insurance company for all dental services rendered. I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical/dental care information requested by my insurance carrier. **The amount estimated to be your portion of treatment, is due at the time dental treatment is provided**. We accept payment in the forms of cash/check, Visa, MasterCard, Discover, Debit cards, Care Credit and Lending Club.

Signature of patient (or parent) _____ Date _____