Welcome to our office! This information will help us take care of you.

MURMANN DENTAL HEALTH

About You

Name: ______________________ ____ ______________________ ______________________
First MI Last Preferred Name

Address: ____

____

Phone Numbers: (____)______________ (____)______________ (____)______________
Cell Work Home

E-mail address: ______________________ Social security # ______________________

How would you like to be reminded about your dental appointment?______________________

Date of Birth: ______________ Age: ________ Gender: ________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: ______________________ Employer: ______________________

Your Health

Are you in good health?__________ Has there been a change in your health in the last year?__________

When did you last see a doctor? ____________ What was done?______________________

Have you been hospitalized in the last 5 years? _____ If so, for what? ______________________

Are you currently under the care of a physician? _____ If so, for what?______________________

Your Medications

NAME OF MEDICATION	DOSE	WHEN TAKEN	WHAT MEDICATION IS FOR

Please mark anything you have had **in the Past with a P** or **Currently with a C**.

__ Allergies
__ Allergy to Amoxicillin
__ Allergy to Aspirin
__ Allergy to Keflex
__ Allergy to Penicillin
__ Allergy to Sulfa
__ Allergy to Zithromax
__ Anemia
__ Angina
__ Arrhythmias
__ Arthritis
__ Artificial Heart Valve
__ Asthma
__ Autism
__ Autoimmune Disease
__ Bleeding Problem
__ Blood Disease
__ Blood Thinner
__ Bone Density Medication
__ Cancer
__ Congenital Heart Disease
__ Coronary Artery Surgery
__ Depression/Anxiety
__ Diabetes
__ Dizziness
__ Dry Mouth/Eyes
__ Epilepsy/Seizures
__ Fainting
__ Head Injuries
__ Heart Attack
__ Heart Disease/Failure
__ Heart Murmur
__ Hepatitis
__ High Blood Pressure
__ HIV
__ Human papillomavirus (HPV)
__ Infective Endocarditis
__ Jaundice
__ Kidney Disease
__ Liver Disease
__ Low Blood Pressure
__ Lung/Breathing Problems
__ Mental Health Disorder
__ Migraines
__ Neurological Disorder
__ Organ Transplant
__ Osteoporosis
__ Pacemaker
__ Pre-Medication
__ Pregnancy
__ Prosthetic Joint Replacement
__ Radiation Treatment
__ Reflux/GERD
__ Sexually Transmitted Disease
__ Sinus Problem
__ Stomach Problem
__ Stroke
__ Thyroid Problem
__ Tuberculosis
__ Ulcer

For Women Only

Are you taking birth control pills? ________ Are you aware antibiotic stop BCP from working? ________

Are you pregnant? ________ If so, when is the due date? ____________ Any nausea? ________

Are you nursing? ____________

Any Other Health Issues or Allergies?

Your Sleep Quality

Do you snore? __________ Have you been diagnosed with sleep apnea? ________________

Do you often feel tired during the day? ________ Why? ____________________________

Do you wake up with a headache? ________ Any problems with your jaws? ________________

Do you grind your teeth? ________ Clench your teeth? ________ Did you use to do either? ________

Do you have a night guard? __________ How often do you wear it? ________________

Your Orthodontic History

Did you have braces? _________ If so, for how long? ______________________________

Do you have retainers? ________ If so, what kind? ______________________________

How often do you wear them? ______________________________

Your Dental History

Any history of complications with or after dental treatment? ______________________________

Have you had any gum problems or gum treatments? ______________________________

When was your last visit to a dentist? ______________ What was done? ______________

What was your last dentist's name and city? ______________________________

Why did you decide to go to a new office? ______________________________

How did you decide to come to our office? ______________________________

Any Dental Problems

How can we help you today? ______________________________

Are any teeth causing you pain? _________ Where? ____________ How long? ____________

Are any teeth sensitive to hot? __________ Where? ____________ How long? ____________

Are any teeth sensitive to cold? __________ Where? ____________ How long? ____________

Do your gums bleed when you brush? ______ When you floss? ______ Where? ____________

Are any of your teeth loose? ______________ If so, where? ______________

Is there anything you want changed about your mouth, teeth or smile? ______________

____

Your Dental Home Care

How often do you brush your teeth? ___________ What kind of toothbrush? ______________

Have you been told you brush too hard? ____________ How often do you floss? ____________

Do you use any other dental home care products? ______________________________

Do you smoke or use tobacco? ______________ How Much? ______________

Notice of Privacy Practices Acknowledgement & Patient Consent to Disclosure

Please Initial that your have been offered a copy of our Notice of Privacy Practices, and consent to disclosure of your information to your insurance company, and any other dental offices that require information to further your treatment.

_______ Initial — Yes, I have been offered a copy of the Notice of Privacy Practices, and consent to disclosure of information to my insurance company, and any other dental offices that require information to further my treatment.

Our Financial Policy

Thank you for choosing us for your dental needs. Please read and initial our payment choices, and missed appoint charge.

Payment: Payment in full is due at the time of service.
We offer several payment options: Cash, Checks, Visa, MasterCard, and Discover.
The adult accompanying the minor is responsible for payment of the service.

MISSED APPOINTMENTS
Once an appointment has been made, please remember that this time has been reserved specifically for you. We reserve the right to charge a fee of $30 per half hour for all canceled or missed appointments without a 24 hour notice.

Please Initial: ________________

SERVICE CHARGES
We will charge $35.00 for returned checks.

INSURANCE
Our office is committed to helping our patients maximize their benefits. As a service to our patients, we will bill insurance companies for services. Your portion must be paid at the time of service. The quality of insurance policies varies greatly; therefore we can estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts.

I understand and agree to this Financial Policy. **Please Initial**: ________________

Signature of patient/responsible party ________________________________ Date ____________

Relationship of signer to the patient: ☐ Self ☐ Parent ☐ Other ________________________