MAGONE FAMILY • DENTAL

Nancy Magone, DMD

Welcome

Today's Date _____ *Home Phone* _____

Soc. Sec. # _____ *Cell Phone* _____

Email _____

Patient's Information (CONFIDENTIAL)

Name _____ *Birthdate* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Check Appropriate Box: ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*

If Student, Name of School/College _____ *City* _____ *State* _____ *Zip* _____

Patient's or Parent's Employer _____ *Work Phone* _____

Business Address _____ *City* _____ *State* _____ *Zip* _____

Spouse or Parent's Name _____ *Employer* _____ *Work Phone* _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ *Phone* _____

Responsible Party

Name of Person Responsible for this Account _____ *Relationship to Patient* _____

Address _____ *Home Phone* _____

Driver's License # _____ *Birthdate* _____ *Financial Institution* _____

Employer _____ *Work Phone* _____ *SS #* _____

Is this Person Currently a Patient in our Office? ☐ *Yes* ☐ *No*

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ *Cash* ☐ *Personal Check* *Credit Card:* ☐ *VISA* ☐ *Mastercard* ☐ *I wish to discuss the office's payment policy*

Insurance Information - *Please notify front desk*

Name of Insured _____ *Relationship to patient* _____

Birthdate _____ *Social Security #* _____ *Date Employed* _____

Name of Employer _____ *Work Phone* _____

Address of Employer _____ *City* _____ *State* _____ *Zip* _____

Insurance Company _____ *Group #* _____ *Policy/ID#* _____

Ins. Co. Address _____ *City* _____ *State* _____ *Zip* _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ *Yes* ☐ *No*

Patient Medical History

Physician _____ *Office Phone* _____ *Date of Last Exam* _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐

If yes, please explain _____

_____

3. Women Only	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Over Please...

	Yes	No
4. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
5. Have you ever taken Phen-Fen/Redux?	☐	☐
6. Do you use tobacco?	☐	☐
7. Do you use controlled substances?	☐	☐
8 Are you wearing contact lenses?	☐	☐

	Yes	No
9. Are you allergic to or have you had any reactions to the following?	☐	☐
Local Anesthetics (e.g. Novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Asprin	☐	☐
Any Metals (e.g. Nickel, Mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		

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

	Yes	No
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Swollen Ankles	☐	☐
Fainting / Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐
Epilepsy / Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Diseases	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐
Congenital Heart Lesions	☐	☐
Cortisone Mediation	☐	☐
Blood Transfusion	☐	☐
Sickle Cell	☐	☐

	Yes	No
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Frequently Tired	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement or Implant	☐	☐
Hepatitis / Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles / Ulcers	☐	☐
Artificial Heart Valve	☐	☐
Prolonged Bleeding	☐	☐
Hemophilia	☐	☐
Other _____		

	Yes	No
Chest Pains	☐	☐
Easily Winded	☐	☐
Stroke	☐	☐
Hay Fever / Allergies	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Liver Disease	☐	☐
Heart Trouble	☐	☐
Respiratory Problems	☐	☐
Mitral Valve Prolapse	☐	☐
Heart Failure	☐	☐
Thyroid Disease	☐	☐
Liver Disease	☐	☐
Psychiatric Treatment	☐	☐
Other _____		

Patient Dental History

Physician _____ *Office Phone* _____ *Date of Last Exam* _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids / foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing?	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9 Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Financial Agreement and Authorization for Treatment

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 treatment of and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and all members of my family promptly. I hereby authorize the release of any pertinent information to my insurance company. I acknowledge that payments will not be delayed or withheld because of any insurance coverage or because of the pendency of claims. I acknowledge that all proceeds of insurance are assigned to this office where applicable and that this office assumes no responsibility for the collection of any proceeds of insurance.

We are pleased to offer you a patient financing program that provides up to twelve months of no interest financing - please see the front desk for details.

I hereby authorize the release of any pertinent information to my insurance company and any other doctors involved in my case.If my account becomes assigned to a collection agency, I agree to pay all collection agency fees, court costs, and attorney fees. I understand that all accounts with a balance over 30 days will be assessed a 1.5 percent late charge per month on the unpaid monthly balance.

_____ _____

Signature of Patient and/or Guardian (SEAL) **Date**

_____ _____

Doctor's Signature **Date**