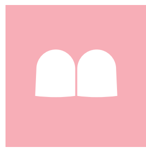

Mohn & Scott Family Dentistry

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ABOUT YOU

Today's Date: ______________

NAME ____
Last First M

I prefer to be called ______________________ ❏ Male ❏ Female

Birthdate __________ Age ____ SS# ______________

Home Address ______________________________

____
City State Zip Code

❏ Single ❏ Married ❏ Divorced ❏ Widowed ❏ Separated

Hm# (_____) ______________ Cell# (_____) ______________

Wk# (_____) ______________ Ext _______

Email ______________________________

EMPLOYER ______________________________

Employer's Address ______________________________

How long there?__________ Occupation ______________

Whom may we thank for referring you? ______________

Other family members seen by us ______________

❏ Previous / ❏ Present Dentist ______________

Date of Last Visit ______________________________

PARENT OR SPOUSE INFORMATION

His/Her Name ______________________________

Employer ______________________________

Wk# (_____) ____________ Ext _______

Birth date __________ Age ____ SS# ______________

PERSON RESPONSIBLE FOR ACCOUNT

Wk# (_____) ____________ Ext ____ Hm# (_____) ____________

Home Address ______________________________

Relationship ______________ SS# ______________

Employer ______________ DL# ______________

INSURANCE

PRIMARY INSURANCE

Dental Coverage ❏ Yes ❏ No

Insurance Co. Name ______________________________

Insurance Co. Address ______________________________

Insurance Co. Phone# (______) ______________________

Group# ______________________________

Insured's Name ______________ Relation ______________

Insured's Birth date __________ Insured's ID# ______________

Insured's Employer ______________________________

Employer's Address ______________________________

SECONDARY INSURANCE

Dental Coverage ❏ Yes ❏ No

Insurance Co. Name ______________________________

Insurance Co. Address ______________________________

Insurance Co. Phone# (______) ______________________

Group# ______________________________

Insured's Name ______________ Relation ______________

Insured's Birth date __________ Insured's ID# ______________

Insured's Employer ______________________________

Employer's Address ______________________________

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

His/Her Name__________________ Relation ______________

Wk# (______) ______________ Hm# (______) ______________

MEDICAL HISTORY

Do you have a physician? ❏ Yes ❏ No

Physician's Name ______________________________

Phone#(_______)______________ Date of Last Visit __________

Are you currently under the care of a physician? ❏ Yes ❏ No

Please explain ______________________________

Payment is due in full at the time of treatment (Unless prior arrangements have been approved)
If this office accepts my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and Deductible that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible tor all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.
I am aware there will be a $50.00 cancellation fee unless 24 hours notice is given.

Signature ______________________________ Date ______________

Continue on back

MEDICAL HISTORY CONTINUED

Your current physical health is ❏ Good ❏ Fair ❏ Poor

Have you had any metal rods, pins, or implants? ❏ Yes ❏ No

Are you taking any Prescription / over-the-counter or herbal supplemental drugs? ❏ Yes ❏ No

Please list each one ______________________________

____

Have you ever taken Fosamax, or other bisphosphonate? ❏ Yes ❏ No

Do you smoke or use tobacco in any other form? ❏ Yes ❏ No

Do you use Marijuana? ❏ Yes ❏ No

Do you use any CBD based products? ❏ Yes ❏ No

Do you use any recreational drugs? ❏ Yes ❏ No

For Women: Are you using a prescribed method of birth control? ❏ Yes ❏ No

Are you pregnant? ❏ Yes ❏ No

Please list any serious medical conditions that you have ever had:

____

____

Are you allergic to any of the following?

❏Y ❏N Aspirin	❏Y ❏N Erythromycin	❏Y ❏N Clindamycin
❏Y ❏N Codeine	❏Y ❏N Latex	❏Y ❏N Vicodin/Norco
❏Y ❏N Penicillin	❏Y ❏N Dental Anesthetics	❏Y ❏N Hydrocodone

Please list any other drugs/materials that you are allergic to

____

❏Y ❏N Abnormal Bleeding	❏Y ❏N Herpes / Fever Blisters
❏Y ❏N Alcohol / Drug Abuse	❏Y ❏N High Blood Pressure
❏Y ❏N Anemia	❏Y ❏N Hospitalized for Any Reason
❏Y ❏N Arthritis	❏Y ❏N Kidney Problems
❏Y ❏N Artificial Bones/Joints/Valves	❏Y ❏N Liver Disease
❏Y ❏N Asthma	❏Y ❏N Low Blood Pressure
❏Y ❏N Blood Transfusion	❏Y ❏N Lupus
❏Y ❏N Cancer / Chemotherapy	❏Y ❏N Mitral Valve Prolapse
❏Y ❏N Colitis	❏Y ❏N Osteoporosis/Paget's Disease
❏Y ❏N Congenital Heart Defect	❏Y ❏N Pacemaker
❏Y ❏N Diabetes	❏Y ❏N Psychiatric Problems
❏Y ❏N Difficulty Breathing	❏Y ❏N Radiation Treatments
❏Y ❏N Emphysema	❏Y ❏N Rheumatic / Scarlet Fever
❏Y ❏N Fainting Spells	❏Y ❏N Infective Endocarditis
❏Y ❏N Frequent Headaches	❏Y ❏N Seizures
❏Y ❏N Glaucoma	❏Y ❏N Shingles
❏Y ❏N Hay Fever	❏Y ❏N Sinus Problems
❏Y ❏N Heart Attack	❏Y ❏N Stroke
❏Y ❏N Heart Murmur	❏Y ❏N Tuberculosis (TB)
❏Y ❏N Hemophilia	❏Y ❏N Ulcers
❏Y ❏N Hepatitis	❏Y ❏N Venereal Diseases / STD

Do you have any other conditions, diseases, etc., not listed above that we should be aware of? ______________________________

____

DENTAL HISTORY

Why have you come to the dentist today? ______________________________

____

____

Are you happy with your smile? ❏ Yes ❏ No

If you could change anything about your teeth or smile, what would it be?

____

Are you currently in pain? ❏ Yes ❏ No

Do you require any antibiotics before dental treatment? ❏ Yes ❏ No

Have you ever had a serious/difficult problem associated with any previous dental work? ❏ Yes ❏ No

Do you fear going to the dentist? ❏ Yes ❏ No

Have you ever had periodontal treatment: gum treatment/surgery or deep cleanings? ❏ Yes ❏ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMD/TMJ)? ❏ Yes ❏ No

Do you grind or clench your teeth? ❏ Yes ❏ No

Do you have any pain, popping, or clicking of your jaw joint? ❏ Yes ❏ No

Do you often chew ice? ❏ Yes ❏ No

Do you have the habit of thumb sucking? ❏ Yes ❏ No

Your current dental health is ❏ Good ❏ Fair ❏ Poor

Do your gums ever bleed? ❏ Yes ❏ No

How many times a week do you floss? _____ A day do you brush?_____

How long do you use a toothbrush before replacing it?____________

Are your teeth sensitive to heat, cold, or sweets? ❏ Yes ❏ No

Are any of your teeth loose, or are you concerned about any teeth loosening? ❏ Yes ❏ No

Do you have any dental implants, dentures, or partials? ❏ Yes ❏ No

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I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature ______________________________ Date ______________

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials ____________ Date ____________

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.