

CARMEN M[©]CAFFREY DMD

Patient Information (Confidential)

Patient's Name: _____ Birth Date: _____

I prefer to be called: _____ Sex: Male Female

Address: _____ SSN: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Physician's name, city and phone: _____

E-mail _____ ** Marital Status: Single Married Divorced Other

Name/ phone of emergency contact: _____

Responsible Party Information

Name & Relationship to Patient: _____ Birth Date: _____ SSN: _____

Home #: _____ Work #: _____ Cell #: _____

Were you referred by one of our patients? Yes No

If yes, whom may we thank? _____ If no, how did you hear about us? _____

Insurance Information

Name of Insured: _____ Birth Date: _____ SSN: _____

Employer: _____ Work #: _____

Name of Insurance Company: _____ Phone #: _____ Group #: _____

If patient is a student, name of college: _____

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Patient Medical History

We are concerned with your total well being, not just your oral health. Please fill out the health questions completely so we may better serve your health needs.

Do you have or have you ever had any of the following:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Hypoglycemia or Diabetes | <input type="checkbox"/> Heart Attack / Trouble | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Epilepsy, Seizures |
| <input type="checkbox"/> Osteoporosis Meds | <input type="checkbox"/> Facial or Head Injuries | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Cancer, Malignancies |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia, Blood Disorders | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting, Black Outs | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> AIDS, HIV Positive | <input type="checkbox"/> Headaches, Migraines | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Glaucoma, Eye Problems |
| <input type="checkbox"/> Ulcers, Digestive Problems | <input type="checkbox"/> Allergies to Medications | <input type="checkbox"/> STD/HPV 16,18 | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Zometa/Aredia Tx |
- Allergic to latex gloves

Please provide details concerning any of the above conditions: _____

Please list any medical conditions not covered by above: _____

List any medications that you currently take: _____

Have you noticed any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Teeth tender to chewing | <input type="checkbox"/> Discomfort in face, head, neck | <input type="checkbox"/> Sensitivity to hot/cold | <input type="checkbox"/> Bleeding or sore gums |
| <input type="checkbox"/> Food caught between teeth | <input type="checkbox"/> Jaw clicking or popping | <input type="checkbox"/> Sensitivity to sweets | <input type="checkbox"/> Hx of periodontal disease |
| <input type="checkbox"/> Recurring sore in mouth | <input type="checkbox"/> Recurring sore around mouth | <input type="checkbox"/> Swelling in mouth | <input type="checkbox"/> Hx of TMD |

Is there anything you would change about your smile? _____

Have you had any problems with previous dental treatment? _____

Do you have any current dental problems or concerns? _____

Office Financial Protocol:

We emphasize that we are **NOT** a party to the contract which exists between you and your insurance company. Consequently, **the patient**, not his/her insurance carrier is responsible for any charges incurred. *Fees are due and payable at the time of treatment.*

I guarantee full payment of all dental charges incurred by the above patient.

Initial: _____
(parent or guardian if patient is a minor)

I understand that if I fail to keep my appointment without prior notification of two business days, a fee may be charged.

Initial: _____
(parent or guardian if patient is a minor)

I give my consent to be contacted regarding dental treatment via _____ *Cell* _____ *E-mail* _____ *Home* _____ *Work.*

Signature: _____

Date: _____