# Welcome To Our Office

In order to render the best professional care it is necessary that we become acquainted with the vital information related to each patient. All information is strictly confidential. We appreciate your co-operation in filling out this form carefully and accurately.
(PLEASE PRINT, Thank you.)

| | | | | | |
|---|---|---|---|---|---|
| Patient's Last Name | | | Given Name(s) | | Home Phone |
| Date of Birth month day year | | Preferred Name | | Cell Phone | |
| Apt. | Address | | | City | Postal Code |
| E-Mail Address | | Employer | | Business Phone | |
| In case of emergency, notify | | | Relationship | | Phone |
| Whom may we thank for referring you? | | | | | |
| Do you have Dental Insurance? | Name of Insured Employee | | Insurance Company | | Employer |
| | Group Policy Number | | Certificate or I.D. Number | | |
| Do you have a 2nd Dental Insurance? | Name of Insured Employee | | Insurance Company | | Policy Holder Date of Birth |
| | Group Policy Number | | Certificate or I.D. Number | | |
| Family Physician | | Address or Phone | Previous Dentist | | Address or Phone |

## MEDICAL HISTORY

| | | YES | NO |
|---|---|---|---|
| 1. | Is your physician currently treating you for any reason? | ☐ | ☐ |
| | If yes, please explain: | | |
| 2. | Have you ever been hospitalized? | ☐ | ☐ |
| | If yes, please explain: | | |
| 3. | Are you currently taking any pills, drugs, patches, injections, or other medications? | ☐ | ☐ |
| | If yes, please list: | | |
| 4. | Are you taking any medication for Osteoporosis (**Important: Include injections/patches**): | ☐ | ☐ |
| 5. | Are you taking any cortisone, steroids, anti-depressants, **blood thinners**, or thyroid medication? | ☐ | ☐ |
| 6. | Do you smoke or vape tobacco or marijuana? | ☐ | ☐ |
| 7. | Do you have any allergies (Medication, drugs, latex etc)? | ☐ | ☐ |
| | If yes, please list: | | |
| 8. | Have you ever been advised to take antibiotics or medications prior to dental treatment or cleanings? | ☐ | ☐ |
| 9. | Women Only: Are you pregnant? If yes, when is your expected due date? | ☐ | ☐ |
| 10. | Do you have or have you ever had any of the following: | | |

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Heart Attack | ☐ | Lung or Breathing Problems or Asthma | ☐ | Stroke/TIA or Aneurysm |
| ☐ | High Blood Pressure | ☐ | Heart disease or chest pains | ☐ | Artificial Joint Replacement |
| ☐ | Heart Murmur | ☐ | Kidney or Liver Problems | ☐ | Epilepsy or Seizures |
| ☐ | Pacemaker or Artificial Heart Valve | ☐ | Hepatitis | ☐ | Syphilis, Gonorrhea, HIV or AIDS |
| ☐ | Rheumatic Fever | ☐ | Thyroid Problems | ☐ | Cancer or Tumours |
| ☐ | Diabetes | ☐ | Stomach or Intestinal Problems | ☐ | Radiation or Chemotherapy |
| ☐ | Blood Disorders or Anemia | ☐ | Tuberculosis | ☐ | Shortness of Breath |
| ☐ | Dementia or Alzheimer's | ☐ | Difficulty Hearing | ☐ | Arthritis |

| | | | |
|---|---|---|---|
| 11. | Is there anything else concerning your health that the doctor should know? | ☐ | ☐ |
| | If yes, please explain: | | |

## DENTAL HISTORY

YES NO

1. Approximate date of Last Check Up: _____
2. Do you have or have you ever had any of the following:

| | | |
|---|---|---|
| ☐ Fillings | ☐ Periodontal Treatment (gum disease) | ☐ Full or Partial dentures |
| ☐ Regular cleanings | ☐ Crowns/Caps | ☐ Orthodontics (Braces) |
| ☐ Recent Dental Xrays | ☐ Extractions (tooth removal) | ☐ Injury to Mouth/Jaw/Head/Neck |
| ☐ Nitrous Oxide (Laughing Gas) | ☐ Root Canal Treatment | ☐ Sedation |
| ☐ Dental Implants | ☐ Mouthguard or snoring appliance | ☐ _____ |

3. Have you ever had an unfavourable dental Experience? _____ ☐ ☐

   If yes, please explain: _____
4. Would you like to improve the cosmetic appearance of your teeth? _____ ☐ ☐
5. Do you use an electric toothbrush? _____ ☐ ☐
6. How often do you brush your teeth? _____ Floss: _____
7. Would you like to maintain and keep your natural teeth for a lifetime? _____ ☐ ☐
8. Are you excessively anxious during dental visits? _____ ☐ ☐
9. Do you presently have or think you have any of the following:

| | | |
|---|---|---|
| ☐ Loose Teeth | ☐ Bleeding Gums | ☐ Broken Fillings |
| ☐ Cavities | ☐ Bad Taste in Your Mouth | ☐ Broken tooth/teeth |
| ☐ Gum disease | ☐ Clicking or Sore Jaw Joint | ☐ Dead or Abscessed Tooth |
| ☐ Headache | ☐ Earache | ☐ Facial Pain |
| ☐ Dry Mouth | ☐ Sensitive teeth to touch, temperature or sweet? | |

10. Would you be interested in a consultation regarding cosmetic, TMJ or headache Botox/Dysport? _____ ☐ ☐
11. What is your primary concern with your teeth/mouth today? _____

## OFFICE PHILOSOPHY AND POLICIES (Please Read)

In an effort to determine a treatment plan that is best for you and your overall dental health, we must make a careful and detailed diagnosis. This involves a thorough examination, often utilizing a prescribed number of xrays and photographs necessary for accuracy.

The long-term success of our efforts will depend on the patients' willingness to maintain their teeth and prevent any future dental problems.

Dr. Tracey Mulhall requires 24 **business** hours' notice before cancelling a scheduled appointment. Your appointment is reserved specifically for you. If notice is not given, you will be charged a cancellation fee.

**Regarding Insurance:** Dental insurance plans are contracts between the insured and the insurance company, not between the insurance company and the dentist. All patients with insurance are responsible for the payment of their own accounts. We will gladly submit claim forms and estimates for you. We offer 2 options for dental insurance. For most insurance companies, we can get payment directly from them (and you would be responsible for the difference) or you can pay us and get reimbursed from your insurance. If you choose to have them pay us directly, we ask you leave a credit card on file to cover any outstanding balance in case of any discrepancies. We also recommended that you check your insurance coverage as insurance plans can be widely varied and confusing. You are responsible for any limitations in your insurance contract. We are always willing to help with any questions that you may have regarding your coverage.

**I, the undersigned, certify that I have thoroughly read all of the information above and that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information. I understand that omitting information may affect my treatment.**

**Signature:** _____ **Date:** _____

**(Parent or Guardian if under 18)**

## INFORMED CONSENT FOR TREATMENT

**I declare that I am of legal age (or representing a minor as a parent/guardian). I understand that there are always inherent risks involved in any dental treatment/procedure. I consent to the performing of dental procedures agreed upon by Dr. Mulhall after discussion with myself. I will assume all responsibility for fees associated with those procedures. I have signed this consent voluntarily, of my own free will, without pressure and in my full senses.**

**Signature:** _____ **Date:** _____

**(Parent or Guardian if under 18)**