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PATIENT NUMBER

Age \_\_\_\_\_ Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female

Last

First

Initial

If Child: Parent's Name \_\_\_\_\_

How do you wish to be addressed \_\_\_\_\_

Single  Married  Separated  Divorced  Widowed  Minor

Residence - Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Address \_\_\_\_\_

Telephone: Res. \_\_\_\_\_ Bus. \_\_\_\_\_

Fax \_\_\_\_\_ Cell Phone # \_\_\_\_\_

eMail \_\_\_\_\_

Patient/Parent Employed By \_\_\_\_\_

Present Position \_\_\_\_\_

How Long Held \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_

Spouse Employed By \_\_\_\_\_

Present Position \_\_\_\_\_

How Long Held \_\_\_\_\_

Who is Responsible for this account \_\_\_\_\_

Drivers License No. \_\_\_\_\_

Method of Payment: Insurance  Cash  Credit Card

Purpose of Call \_\_\_\_\_

Other Family Members in this Practice \_\_\_\_\_

Whom may we thank for this referral \_\_\_\_\_

Patient/parent Social Security No. \_\_\_\_\_

Spouse/Parent Social Security No. \_\_\_\_\_

Someone to notify in case of emergency not living with you \_\_\_\_\_

**DENTAL INSURANCE  
1ST COVERAGE**

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Employer Name \_\_\_\_\_ Yrs. \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Program or policy # \_\_\_\_\_

Social Security No. \_\_\_\_\_

Union Local or Group \_\_\_\_\_

**DENTAL INSURANCE  
2ND COVERAGE**

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Employer Name \_\_\_\_\_ Yrs. \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Program or policy # \_\_\_\_\_

Social Security No. \_\_\_\_\_

Union Local or Group \_\_\_\_\_

**CONSENT:**

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

DATE \_\_\_\_\_



Patient Number grid

PATIENT NUMBER

Patient's Name Last First Initial Date of Birth

- 1. Purpose of initial visit
2. Are you aware of a problem?
3. How long since your last dental visit?
4. What was done at that time?
5. Previous dentist's name
6. When was the last time your teeth were cleaned?
7. Have you made regular visits?
8. Were dental x-rays taken?
9. Have you lost any teeth or have any teeth been removed?
10. Have they been replaced?
11. How have they been replaced?
12. Are you unhappy with the replacement?
13. Would you like to know about permanent replacements?
14. Have you ever had any problems or complications with previous dental treatment?
15. Do you clench or grind your teeth?
16. Does your jaw click or pop?
17. Have you experienced any pain or soreness in the muscles or your face or around your ear?
18. Do you have frequent headaches, neckaches or shoulder aches?
19. Does food get caught in your teeth?
20. Are any of your teeth sensitive to:
21. Do your gums bleed or hurt?
22. Do you experience dry mouth?
23. How often do you brush your teeth?
24. Do you use dental floss?
25. Are any of your teeth loose, tipped, shifted or chipped?
26. Are you unhappy with the appearance of your teeth?
27. How do you feel about your teeth in general?
28. Do you feel your breath is offensive at times?
29. Have you ever had gum treatment or surgery?
30. Have you had any orthodontic work?
31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?
32. Do you have any questions or concerns?

COMMENTS

Large empty box for patient or dentist comments.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE
PATIENT'S / GUARDIAN'S SIGNATURE DATE
DENTIST'S SIGNATURE DATE

ANEST.

MED. ALERT

DENTAL HISTORY

MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?

Women: Are you Pregnant/Trying to get pregnant? Taking oral contraceptives? Nursing?

Are you allergic to any of the following? Aspirin, Penicillin, Codeine, Local Anesthetics, Acrylic, Metal, Latex, Sulfa drugs, Other

- Do you have, or have you had, any of the following? AIDS/HIV Positive, Alzheimer's Disease, Anaphylaxis, Anemia, Angina, Arthritis/Gout, Artificial Heart Valve, Artificial Joint, Asthma, Blood Disease, Blood Transfusion, Breathing Problem, Bruise Easily, Cancer, Chemotherapy, Chest Pains, Cold Sores/Fever Blisters, Congenital Heart Disorder, Convulsions, Cortisone Medicine, Diabetes, Drug Addiction, Easily Winded, Emphysema, Epilepsy or Seizures, Excessive Bleeding, Excessive Thirst, Fainting Spells/Dizziness, Frequent Cough, Frequent Diarrhea, Frequent Headaches, Genital Herpes, Glaucoma, Hay Fever, Heart Attack/Failure, Heart Murmur, Heart Pacemaker, Heart Trouble/Disease, Hemophilia, Hepatitis A, Hepatitis B or C, Herpes, High Blood Pressure, High Cholesterol, Hives or Rash, Hypoglycemia, Irregular Heartbeat, Kidney Problems, Leukemia, Liver Disease, Low Blood Pressure, Lung Disease, Mitral Valve Prolapse, Osteoporosis, Pain in Jaw Joints, Parathyroid Disease, Psychiatric Care, Radiation Treatments, Recent Weight Loss, Renal Dialysis, Rheumatic Fever, Rheumatism, Scarlet Fever, Shingles, Sickle Cell Disease, Sinus Trouble, Spina Bifida, Stomach/Intestinal Disease, Stroke, Swelling of Limbs, Thyroid Disease, Tonsillitis, Tuberculosis, Tumors or Growths, Ulcers, Venereal Disease, Yellow Jaundice

Have you ever had any serious illness not listed above?

Comments: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

Dr. Brophy and her team would like to welcome you to the practice. We are committed to providing the best dental care for your particular needs. We will only be able to accomplish this by spending adequate time necessary to diagnose and treat your dental needs. This treatment is very important to your health and should not be postponed by financial concerns.

Patients under the age of 18 must be accompanied by a parent. It is necessary for the parent to give permission for the treatment and to sign off on the medical history of the patient. The parent who accompanies the child to the office is responsible for payment of the fee.

To enable you to proceed without delay our office offers several financial options. We encourage you to select a financial arrangement that works best in your budget. For your convenience we offer the following financial arrangements when the total cost of your treatment exceeds \$500. (Fees less than \$500 are to be paid at the time of service.) Our philosophy is to make dentistry affordable to everyone and we hope this helps you to make us your dental home.

1. Our patients with insurance coverage are expected to pay the patient portion of the fees directly to our office. As a courtesy, we will file your insurance claims.
2. The patient portion of the fee for a crown may be paid in two installments: 50% of the fee is payable at the first visit and the remaining 50% is due when the crown is seated.
3. The patient portion of the fee for fixed or removable prosthetics may be paid in three equal installments. The first 33% is due at the initial visit, the second 33% is due at the try in visit, and the remaining 34% is due at the delivery visit.
4. The fee for treatment may be financed through Care Credit, upon credit approval.
5. We accept most major credit cards: Visa, MasterCard, Discover & CareCredit.

#### DENTAL INSURANCE

I understand my dental insurance is a contract between the insurance carrier and myself, not between Mahoning Valley Family Dental or Dr. Brophy and the insurance carrier. As such, I understand that I am responsible for the full amount of all fees incurred for dental treatment. Any payments received by Dr. Brophy from my insurance carrier will be credited to my account or refunded to me if I have paid the fees in full.

#### FINANCIAL RESPONSIBILITY

I/We agree and personally guarantee, in consideration of services and materials provided by Dr. Brophy to be responsible for payment in full of all dental fees. In the event that this matter is turned over to an attorney for collections, I/We agree that I/We shall pay all costs incurred in the collection of this debt.

Print Patient's Name: \_\_\_\_\_

Patient/ Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Mahoning Valley Family Dental Care

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

*\*You May refuse to Sign This Acknowledgement\**

I, (PATIENT NAME) \_\_\_\_\_, have been offered  
a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{PATIENT /GUARDIAN SIGNATURE}

\_\_\_\_\_  
{DATE}

\_\_\_\_\_  
**FOR OFFICE USE ONLY**  
\_\_\_\_\_

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)