MORGAN CROSSING DENTAL

Welcome to our office – Please tell us about yourself

Name:_____
Last First Middle
Preferred Name:_____ ☐ Male ☐ Female Birthdate:_____

Address:_____City _____Postal Code _____

Home Phone:_____Work Phone_____

Cell Phone_____Email Address_____

Do you prefer to be contacted for appointment confirmation via ***PHONE*** or ***EMAIL*** *(Please circle preference)*

How did you hear about our office?_____

Emergency Contact:

Name:_____ Relationship:_____Phone:_____

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name:_____ Physician's phone:_____

Are you currently under the care of a physician? ☐ Yes ☐ No If yes, Please Explain:_____

Do you chew tobacco? ☐Yes ☐ No Do you smoke cigarettes? ☐Yes ☐ No, If yes for how long?_____

Have you had any metal rods, pins or implants placed? ☐ Yes ☐ No, If yes where? _____

Are you taking any medications? ☐ Yes ☐ No, If yes please list: _____

_____

Have you ever had any surgical Procedures? ☐ Yes ☐ No, If yes please list: _____

If Female Please Answer
Are you taking Birth Control Pills? ☐ Yes ☐ No Are you currently Pregnant or Breast feeding? ☐ Yes ☐ No

Please circle any of the following that apply to you:

HIV / AIDS	Congenital Heart Lesions	Heart Pacemaker	Psychiatric Problems	Allergies/ Hive	Organ Transplant
Cortisone/ Steroid Meds	Heart Surgery	Radiation/Chemo	Yellow Jaundice	Angina Pectoris	Heart Disease/ Attack
Diabetes	Difficulty Breathing	Scarlet Fever	Colitis / Crohns	Drug / Alcohol Abuse	Mitral Valve Prolapse
Hepatitis A B C	Sickle Cell Disorder	Artificial Heart Valve	Emphysema	Facial Surgery	Cold Sores
Sinus Trouble	Artificial Joints	Epilepsy/ Seizures	High/ Low Blood Pressure	Stomach Problems	Heart Failure/ Murmur
Arthritis/ Rheumatism	Fainting/ Dizzy Spells	Rheumatic Fever	Stroke	Asthma	Sexually trans. Disease
Frequent Headaches	Kidney Trouble	Thyroid Disease	Blood Disorders /Transfusion	Glaucoma	Cancer
Liver Disease	Tuberculosis	Bruise Easily	Joint Replacement	Lung Disease	Ulcer

Allergies:

Acetaminophen	Demerol	Percocet	Ativan	Triazolam	LATEX	Valium
Novocain	Aspirin	Sleeping Pills	Sulpha	Codeine	Dental Anesthetic	Clindamycin
Erythromycin	Penicillin	Other Antibiotics	Ibuprofen	Jewellery	Tetracycline	

Are you aware of being allergic to any other medications or substances? Yes/ No _____

MORGAN CROSSING DENTAL

DENTAL HISTORY

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you had any pain/discomfort in your jaw joint?(TMJ) ☐ Yes ☐ No

Are you under stress? (new job, moving, relationships) ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Is there is anything you would like to change about your smile? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

How many times do you: floss/week?_____ brush/day?_____

Are your teeth sensitive to heat, cold or anything else? ☐ Yes ☐ No

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

Have you ever had any unfavourable dental experience? ☐ Yes ☐ No

When was your last dental visit and cleaning?_____

Why did you leave your previous dentists?_____

How can we accommodate you better during your dental visit?_____

We like to take the least amount of X-rays possible, for this reason please provide contact information for your previous dental office._____

Here at Morgan Crossing Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening	Sealant	Veneers
Night/Sport Guards	Crown and Bridge	Smile Makeover
Dental Implants	Teeth Straightening	Velscope (oral cancer screening)

CONSENT

* I authorize the doctor to perform diagnostic procedures, treatment and provide medication necessary for proper dental care. I also consent for this office to attain my previous dental records.

* I, the undersigned, certify that I (or my dependent) have provided Morgan Crossing Dental with my insurance coverage information and I assign my benefits directly to Morgan Crossing Dental, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments. I authorize the use of this signature on all submissions.

* I consent that the above information is correct to the best of my knowledge. I 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 personal and/or medical status. I also understand **I am required to give 24 hours notice of any changes or cancellations of my appointments to avoid charges**.

Signature: _____ Date:_____

Patient ☐ Parent ☐ Guardian ☐