Mallard Family Dental Center

In Park Center

Timothy C. Paventy, DMD

1 PATIENT INFORMATION

Today's Date: _____

Name: _____
LAST FIRST M.I. MR MRS MS DR

I prefer to be called: _____ ❑ Male ❑ Female

Birthdate: ___/___/___ Age: _____ SS# _____

Home Address: _____
APT / CONDO #

_____
CITY STATE ZIP

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home # _____ Cell # _____

Wk # _____ Ext ____ Email _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Who may we **Thank** for referring you? _____

Other family members seen by us: _____

Previous Dentist: _____

Last Visit Date: _____

2 PERSON RESPONSIBLE FOR ACCOUNT

Their Name: _____

Employer: _____

Wk # _____ Ext ____ HM # _____

Birthdate: ___/___/___

Billing Address: _____

Relationship to patient _____

3 DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone # _____

Group # (Plan, Local, or Policy #) _____

Subscriber I.D. # _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthday: ___/___/___ & SS # _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #) _____

Subscriber I.D. # _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthday: ___/___/___ & SS # _____

Insured's Employer: _____

4

I understand that if payments extend beyond 60 days from the date of first billing, to pay 1.75% per month on unpaid balance (annual rate of 21%) with a minimum charge of 50¢ per month.

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

5

I understand that the information that I have given 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 with my informed consent that I may need during diagnosis and treatment.

_____
Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

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6 INSURANCE OFFICE POLICY

It is the policy of this office to submit all insurance claims providing the proper information has been supplied by the patient. The patient is ultimately responsible for the account in full regardless of insurance coverage. If there is any question of insurance coverage for a particular procedure, preauthorization is recommended. If you have any questions regarding this policy please ask the front office. I understand I am responsible for the amount in full. **Initials** _____

Notice of Privacy Practices

I have received a copy of this offices Notice of Privacy Practices. **Initials** _____

Release of Records

If requested by myself I authorize the release of my dental records to the dentist of my choice. I acknowledge that data to be released MAY INCLUDE material that is protected by Federal Law
Initials _____

_____ _____

Signature of Patient or Responsible Party Date

_____

Witness

Mallard Family Dental Center

DENTAL REGISTRATION AND HEALTH HISTORY

7

Patient's Name : _____ Date _____

Answers to the following questions are for our records only and will be considered confidential.

1. Date of last physical examination _____ Physician's Name / Phone # _____
2. Have you been under the care of a medical doctor during the past two years? Yes _____ No
3. Have you had surgery? Yes _____ No
4. Have you taken any medications or drugs during the past two years? Yes _____ No
5. Are you taking any vitamins, herbal supplements or "cures"? Yes No
6. Have you ever had any excessive bleeding requiring special treatment? Yes No
7. Are you having dental pain or discomfort at this time? Yes No
8. Do you feel nervous about having dental treatment? Yes No
9. Have you ever had a bad experience in a dental office? Yes No
10. Is there anything you dislike about your smile? If yes, please explain Yes _____ No
11. Is there anything you would like to speak with the Doctor about in private? Yes No

ALLERGIES

Aspirin	Local Anesthetic
Barbiturates	Penicillin
Codeine	Sulfa
Iodine	Metals
Latex	Other: _____

MEDICATIONS

Please list medications you are currently taking:

_____

_____

_____

Pharmacy: _____

8

Have you ever experienced any of the following problems with your jaw:

Clicking?	Yes	No
Pain in or around your ears?	Yes	No
Difficulty opening or closing?	Yes	No
Do you have a history of trauma to your jaw?	Yes	No
Have you ever been diagnosed with TMJ/TMD?	Yes	No
Do you have any sores, lumps or growths in or near your mouth? Around your ears?	Yes	No
Have you ever had difficult extractions in the past?	Yes	No
Have you ever had prolonged bleeding following extractions?	Yes	No
Do you habitually clench or grind your teeth during the day or night?	Yes	No
Have you ever taken Redux or Pondimin (Fen Phen)?	**Yes**	**No**
Have you ever or are you taking medications for cancer or osteoporosis such as Boniva, Evista, Fosamax, Actenol?	**Yes**	**No**

Do you currently have any problems listed below: (Please circle all that apply)

Swelling	Bad Taste
Bleeding Gums	Loose Teeth
Sensitive to:	
Hot	Cold
Biting/Pressure	Sweets

Other: _____

Problem with bad breath (Halitosis)	Yes	No
Do you have trouble chewing?	Yes	No
Does food collect between your teeth?	Yes	No
Have you ever had instructions in oral hygiene?	Yes	No

Do you participate in recreational activities?	Yes	No	What? _____
Have you ever been told you have gum problems?	Yes	No	
Have you ever needed to see a periodontist?	Yes	No	
Is there anything related to your medical or dental history that you have not indicated above?	Yes	No	

If yes, please explain: _____

(Continued on Back)

9 Place a mark on yes or no to indicate if you have had any of the following:

Chest Pain	Yes	No	Sinus Trouble	Yes	No	Use of Tobacco Products	Yes	No
Heart Failure	Yes	No	Thyroid Disease	Yes	No	Radiation Therapy	Yes	No
Heart Disease or Attack	Yes	No	Anemia	Yes	No	Cold Sores	Yes	No
Angina Pectoris	Yes	No	Shortness of Breath	Yes	No	Hives or Skin Rash	Yes	No
Heart Problems	Yes	No	Ulcers	Yes	No	Herpes	Yes	No
Heart Surgery	Yes	No	Surgery	Yes	No	Glaucoma	Yes	No
High Blood Pressure	Yes	No	Emphysema	Yes	No	Arthritis	Yes	No
Heart Pacemaker	Yes	No	Fainting or Dizzy Spells	Yes	No	Any Type of Dental Implant	Yes	No
*Heart Murmur	Yes	No	Eating Disorder	Yes	No	Dentures or Partials	Yes	No
*Congenital Heart Problems	Yes	No	Epilepsy or Seizures	Yes	No	Birth Defects	Yes	No
*Rheumatic Fever	Yes	No	Persistent Cough	Yes	No	HIV Positive, ARC, AIDS	Yes	No
*Artificial Joints	Yes	No	Tuberculosis (TB)	Yes	No	Hay Fever	Yes	No
*Any type of transplant	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
*Mitral Valve Prolapse	Yes	No	Hepatitis A (Infectious)	Yes	No	Jaundice	Yes	No
*Steroid Treatment	Yes	No	Hepatitis BA (serum)	Yes	No	Kidney Trouble	Yes	No
Psychiatric Treatment	Yes	No	Hepatitis C or other	Yes	No	Hemophilia	Yes	No
Liver Disease	Yes	No	Stroke	Yes	No	Diabetes	Yes	No
Sickle Cell Disease	Yes	No	Drug Addiction	Yes	No	Chemotherapy	Yes	No
Blood Transfusion	Yes	No	Alcoholism	Yes	No	Cancer (type:)	Yes	No

***Antibiotic pre-medication may be required prior to your appointment.**

WOMEN: Are you pregnant now? Yes No If yes, what is your due date? _____

Are you currently breast feeding? Yes No

Are you taking oral contraceptives? Yes No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier my pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ _____

Signature of patient or guardian Date

10 OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

MEDICAL HISTORY UPDATE

	DATE	COMMENTS	SIGNATURE
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			