MOHR & MOHR SMILES
Sedation, Family, & Cosmetic Dentistry

PATIENT INFORMATION

CONFIDENTIAL

Welcome!

Date: _____

Name: _____ Patient#: _____
first middle last

Address: _____ email: _____
street city state zip

TELEPHONE

Mobile: _____ **Work:** _____
Home: _____ **Fax:** _____
When is the best time to reach you? _____
Best day: _____ **Where:** _____
In the event of an emergency, who should we contact?
Name: _____
Relationship: _____
Work#: _____ **Home#:** _____

Birthdate:

_____

✔ Check appropriate box:

❑ **Minor** ❑ **Single**
❑ **Married** ❑ **Divorced**
❑ **Widowed** ❑ **Separated**

Patient's or Parent's Employer: _____ Occupation: _____

Business Address: _____
street city state zip

Spouse or parent's name: _____ Employer: _____ Work Phone: _____

Social Security Number: _____ Driver License Number: _____

How did you hear about our office? _____

RESPONSIBLE PARTY

If patient is a minor, please fill out below.

Name of person responsible for this account: _____ Relationship: _____

Address: _____
street city state zip

Home Phone: _____ Soc. Sec. #: _____ Birthdate: _____

Driver's license #: _____

Employer: _____ Work Phone: _____

Is this person currently a patient in our office? ❑ Yes ❑ No

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INSURANCE INFORMATION

Please present your insurance card to the front desk.

Name of Insured: _____ Relationship: _____

Birth Date: _____ Social Security #: _____ Date employed: _____

Employer: _____ Work Phone: _____

Insurance Company: _____ Group #: _____

Insurance Phone #: _____

Do you have any secondary insurance? ❑ Yes ❑ No If yes, complete the following

Name of Insured: _____ Relationship: _____ Birth Date: _____

Social Security #: _____ Employer: _____ Date employed: _____

Group #: _____ Insurance Company: _____

Insurance Phone #: _____

FINANCES

Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment. Please check the option which you prefer. If you have any questions concerning financial arrangements, it will be our pleasure to assist you. There will be a $50 charge for appointments not cancelled within a 48 hour time period.

❑ Cash ❑ Personal Check

❑ VISA ❑ MASTERCARD ❑ DISCOVER

❑ American Express ❑ Care Credit

Card # _____

Exp. Date _____

Authorization, Release, & Agreement to Pay for Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

I agree to pay for all professional fees and treatment. I further agree to pay any collection and legal fees on any balance over 45 days old, should this be a necessary means for collection.

_____ _____

Signature of patient or parent if minor ***Date***

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MEDICAL HEALTH HISTORY

Name: _____ Date: _____

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____

Please mark yes or no if you have or have had any of the following:

Anemia	No	Yes	Are you allergic to or have you had a reaction to:		
Diabetes - Type I or Type II (circle one)	No	Yes	Local Anesthetics?	No	Yes
Epilepsy	No	Yes	Penicillin?	No	Yes
Hepatitis, Any Form	No	Yes	Aspirin?	No	Yes
Asthma	No	Yes	Codeine, Valium or other sedatives?	No	Yes
Bronchitis	No	Yes	Are you a smoker? If yes, How much per day?	No	Yes
Obstructive Sleep Apnea	No	Yes	Abnormal Blood Pressure? Please indicate. /S /D	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Are you required to premedicate before dental treatment?	No	Yes
Immuno Suppression	No	Yes	Do you/have you ever take Fosamax, Actonel or Boniva?	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	If yes, please indicate how long:		
Abnormal Heart Condition	No	Yes	Are you taking any herbal supplements?	No	Yes
Kidney Disease	No	Yes	Have you had bacterial endocarditis?	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Do you have a prosthetic cardiac valve?	No	Yes
Angina	No	Yes	Do you have a congenital heart disease (excluding Mitral	No	Yes
Psychosis	No	Yes	Valve Prolapse)? If yes, please specify		
Other Infections	No	Yes	Have you had a cardiac transplant?	No	Yes
Joint Replacement	No	Yes	Have you had a coronary stent placed?	No	Yes
Glaucoma	No	Yes	If yes, when?		
Abnormal Bleeding from a cut	No	Yes	Women: Are you pregnant?	No	Yes
Liver Disease (including Jaundice)	No	Yes	If no, are you planning a pregnancy in the near future?	No	Yes
Cancer, Osteoporosis, Multiple Myeloma	No	Yes	Are you a nursing mother?	No	Yes
Do you consume any form of grapefruit?	No	Yes	Are you taking birth control pills?	No	Yes
Are you taking Tagamet (Cimetidine)?	No	Yes	Other:		
Do you take antacids?	No	Yes			

Please list any medications and herbal supplements you are currently taking:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Weight: _____

Diet: Restricted Diet _____

How many meals a day _____

Food Allergies _____ Sugar in your diet ❑ None ❑ Slight ❑ Moderate ❑ High

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I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____

Patient (Print Name) *Patient Signature* *Date*

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PATIENT DENTAL HISTORY

Patient Name _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	❑	❑
2. Are your teeth sensitive to hot or cold liquid/foods?	❑	❑
3. Are your teeth sensitive to sweet or sour liquid/foods?	❑	❑
4. Do you feel pain to any of your teeth?	❑	❑
5. Do you have any sores or lumps in or near your mouth?	❑	❑
6. Have you had any head, neck or jaw injuries?	❑	❑
7. Have you experienced any of the following problems in your jaw?	❑	❑
a) Clicking?	❑	❑
b) Pain (joint, ear, side of face)?	❑	❑
c) Difficulty in opening or closing?	❑	❑
d) Difficulty in chewing?	❑	❑
8. Do you have frequent headaches?	❑	❑
9. Do you clench or grind your teeth?	❑	❑
10. Do you bite your lips or cheeks frequently?	❑	❑
11. Have you ever had any difficult extractions in the past?	❑	❑
12. Have you had any orthodontic work?	❑	❑
13. Have you ever had prolonged bleeding following extractions?	❑	❑
14. Have you ever had instruction on the correct method of brushing your teeth?	❑	❑
15. Have you ever had instructions on the care of your gums?	❑	❑
16. Have you ever had periodontal treatment or has it been recommended to you in the past?	❑	❑
17. Do you want your treatment done while sedated?	❑	❑

What is the reason for your visit today? _____

_____

Date of last dental visit _____

What was done at your last dental visit? _____

_____

Do you have any dental problems now? Yes No

If yes, please describe: _____

_____

Are you satisfied with your teeth's appearance? Yes No

What would you change about your smile? _____

Do you brush, floss or use any other dental aids? _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

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.

SIGNATURE X _____

PATIENT, PARENT, OR GUARDIAN DATE

Mohr & Mohr Smiles, P.C.
Drs. Cameron and Beth Mohr

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of the Notice of Privacy Practices.

_____
Please Print Patient Name

_____
Patient Signature (Parent Signature if Minor)

_____
Date

You may email me at
_____
I would like to receive text reminders at (cell phone #)
_____

You may disclose information to my family members or non-family members. Please list name, phone number and relationship.

Name Phone Number Relationship

_____
_____
_____
_____
_____
_____

For Office Use Only

We have attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to the following:

- ☐ Individual refused to sign acknowledgement of receipt even though Notice of Privacy Practices were reviewed by individual
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented the office from obtaining acknowledgement
- ☐ Other (Please Specify)
  _____

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