WELCOME TO METAIRIE DENTAL CENTRE!

PATIENT INFORMATION

PATIENT____ DATE______________________

PARENT/GUARDIAN____PARENT/GUARDIAN BIRTHDATE___________________

ADDRESS____ CITY___________________________ STATE________ ZIP__________

M___ F___ BIRTHDATE___________________________ AGE________ MARITAL STATUS:S/M/W/D TITLE:MR/MRS/MS/DR

DRIVERS LIC # ____________________________________ SOCIAL SECURITY #____

HOME PHONE_____________________________________ CELL PHONE____

EMAIL ADDRESS___________________________________ WORK PHONE____

OCCUPATION______________________________________ EMPLOYER____

EMPLOYER ADDRESS________________________________ CITY___________________________ STATE________ ZIP_________

WHOM MAY WE THANK FOR REFERRING YOU? _________________________________ RELATIONSHIP _____________________

DENTAL INSURANCE

NAME OF POLICY HOLDER___________________________ POLICY HOLDER BIRTHDATE__________________________________

RELATIONSHIP TO PATIENT_________________________ INSURANCE COMPANY____

INS CO PHONE____________________________________ SUBSCRIBER #________________________ GROUP#______________

DO YOU HAVE SECONDARY DENTAL INSURANCE COVERAGE? Y N

NAME OF POLICY HOLDER___________________________ POLICY HOLDER BIRTHDATE__________________________________

RELATIONSHIP TO PATIENT_________________________ INSURANCE COMPANY____

INS CO PHONE____________________________________ SUBSCRIBER #_________________________ GROUP#_____________

IN CASE OF EMERGENCY, CONTACT (PLEASE SPECIFY SOMEONE WHO DOES NOT LIVE WITH YOU)

NAME____ RELATIONSHIP____

CELL PHONE ____________________________________ WORK PHONE____

DENTAL HISTORY

REASON FOR TODAYS VISIT______________________ FORMER DENTIST______________________ CITY/STATE_______________________

DATE OF LAST VISIT____________________________ DATE OF LAST DENTAL XRAYS____

HOW OFTEN DO YOU FLOSS______________________ HOW OFTEN DO YOU BRUSH____

CHECK ANY THAT APPLY:

	YES	NO		YES	NO		YES	NO
BAD BREATH	___	___	**BLEEDING GUMS**	___	___	**ORTHODONTIC TREATMENT**	___	___
LIP BLISTERS	___	___	**LOOSE TEETH**	___	___	**PERIODONTAL TREATMENT**	___	___
MOUTH BLISTERS	___	___	**TONGUE BURNING**	___	___	**CHEWING ON ONE SIDE**	___	___
DRY MOUTH	___	___	**FINGERNAIL BITING**	___	___	**JAW PAIN OR TIRED**	___	___
GRINDING TEETH	___	___	**MOUTH PAIN**	___	___	**SWOLLEN/TENDER GUMS**	___	___
LIP OR CHEEK BITING	___	___	**MOUTH BREATHING**	___	___	**PAIN AROUND EAR**	___	___
BROKEN FILLINGS	___	___	**SORES IN MOUTH**	___	___	**FOOD PACKING BETWEEN TEETH**	___	___
SENSITIVITY TO COLD	___	___	**SENSITIVITY TO HEAT**	___	___	**SENSITIVITY TO SWEETS**	___	___
SENSITIVITY TO BITING	___	___	**GROWTHS IN MOUTH**	___	___	**JAW CLICKING/POPPING**	___	___
CIGARETTE SMOKING	___	___	**PIPE SMOKING**	___	___	**CIGAR SMOKING**	___	___

HEALTH HISTORY

PHYSICIANS NAME_______________________ PHONE____________________ DATE OF LAST VISIT_______________

	YES	NO		YES	NO		YES	NO
AIDS/HIV	___	___	ARTHRITIS, RHEUMATISM	___	___	UNUSUAL BLEEDING WITH EXTRACTIONS	___	___
ANEMIA	___	___	ARTIFICIAL JOINTS	___	___	BLOODY OR PERSISTANT COUGH	___	___
ASTHMA	___	___	BACK PROBLEMS	___	___	ARTIFICIAL HEART VALVE	___	___
EPILEPSY	___	___	BLEEDING DISORDER	___	___	CHEMICAL DEPENDENCY	___	___
BLOOD DISEASE	___	___	LOW BLOOD PRESSURE	___	___	CORTISONE TREATMENTS	___	___
HEART MURMUR	___	___	CHEMOTHERAPY	___	___	MITRAL VALVE PROLAPSE	___	___
EMPHYSEMA	___	___	CIRCULATORY PROBLEMS	___	___	HIGH BLOOD PRESSURE	___	___
DIABETES	___	___	FAINTING/DIZZINESS	___	___	HEPATITIS TYPE_______________	___	___
HEART ATTACK	___	___	GLAUCOMA	___	___	HEADACHES	___	___
FIBROMYALGIA	___	___	KIDNEY DISEASE	___	___	NERVOUS PROBLEMS	___	___
HEART PROBLEMS	___	___	PSYCHIATRIC CARE	___	___	RADIATION TREATMENT ___	___	
STROKE	___	___	RESPIRATORY DISEASE	___	___	RHUEUMATIC FEVER	___	___
LIVER DISEASE	___	___	SCARLET FEVER	___	___	SHORTNESS OF BREATH	___	___
SINUS TROUBLE	___	___	CARDIAC PACEMAKER	___	___	SWELLING FEET/ANKLE	___	___
SKIN RASH	___	___	THYROID PROBLEMS	___	___	TUMORS OR GROWTHS	___	___
CANCER	___	___	VENEREAL DISEASE	___	___	SWOLLEN NECK GLANDS	___	___
TONSILITIS	___	___	ULCERS	___	___	TUBERCULOSIS	___	___
WOMEN:								
ARE YOU PREGNANT?	___	___	NURSING?	___	___	TAKING BIRTH CONTROL PILLS?	___	___

MEDICATIONS

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: ___

____

____

____

____

____

____

____

____

ALLERGIES

ASPIRIN ___ BARBITUATES

___ CODEINE ___ IODINE

___ LATEX ___ LOCAL ANESTHETIC

___ PENICILLIN ___ SULFA DRUGS

OTHER ALLERGIES____

____

____

____

____

CONSENT FOR TREATMENT

BY SIGNING I GIVE MY CONSENT FOR DENTAL TREATMENT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES INCURRED AND THAT PAYMENT IS EXPECTED AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY COST RELATED TO THE COLLECTION OF A DELINQUENT ACCOUNT AND AGREE TO PAY LEGAL/ATTORNEYS FEES IN RELATION TO COLLECTING ANY UNPAID BALANCE FOR SERVICES RENDERED.

_____________________________________ _________________

PATIENT/GUARDIAN SIGNATURE DATE

ASSIGNMENT AND RELEASE

I ASSIGN DIRECTLY TO DR. MURPHY ALL INSURANCE BENEFITS, 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 RE - LEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS, I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. I UNDERSTAND THAT INSURANCE BENEFITS ESTIMATED ARE NOT A GUARANTEE OF PAYMENT OR COVERAGE. I UNDERSTAND THAT PREAUTHORIZATION FOR DENTISTRY WILL ONLY BE MADE AT MY REQUEST.

_____________________________________ _________________

PATIENT/GUARDIAN SIGNATURE DATE