Ronald R. Morín, DDS, FAGD
Fellow, Academy of General Dentistry
8619 Potranco Road San Antonio, TX 78251
210-680-9980

DATE _____

WELCOME! **We're glad you're here. Our goal is to deliver the highest quality restorative, cosmetic and preventive dental care available. We want to help you keep your teeth for a lifetime, and we look forward to getting to know you.**

Please print:

PATIENT INFORMATION:

Name _____ **Social Security #** _____

Date of birth _____ **Age** _____ **Marital Status:** □ **Minor** □ **Single** □ **Married** □ **Widowed** □ **Separated**

Address _____**City** _____ **State**____ **Zip**_____**__ Spouse's name** _____

Home Phone _____ **Work #** _____ **Cell #** _____ **E-mail** _____

Employer _____ **Physician's name** _____ **Date last medical visit** _____

If student, name of school/college _____ □ **Full time** □ **Part time**

Whom may we thank for referring you? _____

What is the name you would like us to call you? _____

DENTAL HISTORY:

Date of last dental visit _____

Are you having any discomfort right now? YES NO What is the reason for your visit today?_____

_____

Have you ever had a bad experience in the dental office? YES NO

ARE ANY OF YOUR TEETH SENSITIVE:
To heat or cold? YES / NO Sweets? YES/ NO When biting or chewing? YES/ NO

HAVE YOU NOTICED:

Bleeding gums**?**	YES	NO
Bad breath or taste?	YES	NO
A family history of gum disease or tooth loss?	YES	NO
Frequent canker sores/cold sores/lesions?	YES	NO
Catching food in between teeth?	YES	NO
Any loose teeth?	YES	NO
A severely sore mouth?	YES	NO
A bite that feels uncomfortable or unusual?	YES	NO

DO YOU:

Clench or grind your teeth while awake or asleep?	YES	NO
Have difficulty opening your mouth?	YES	NO
Hear noises from the jaw joint?	YES	NO
Have a jaw that gets "stuck," "locked" or "goes out"?	YES	NO
Have pain in or about the ears or cheeks?	YES	NO

HAVE YOU EVER:
Had a serious injury to your jaw, head, or neck? YES NO
Been treated for a temporomandibular disorder (TMJ/TMD)? YES NO If so, when, how, and by whom? _____
_____

What are some questions about dentistry and oral health that you have never had adequately answered?

_____

_____

What cosmetic procedures, if any, might you be interested in? **Smile Design** **Bonding** **Veneers**

Gum Recontouring **Porcelain Crowns and Bridges** **Implants** **Inlays and Onlays** **Teeth Whitening**

MEDICAL HISTORY:

Are you under a physician's care now? Yes No If yes, please explain: _____

_____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Are you taking any medications pills, or drugs? Yes No If yes, please list: _____

_____

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

How would you rate your physical health compared to others your age? ○ Excellent ○ Good ○ Fair ○ Poor

Do you have a family history of heart disease? ○ No If ○Yes, ○ Mother ○ Father ○ Grandmother ○ Grandfather ○ Other _____

Any immediate genetic family members diagnosed with cancer? ○ Father ○ Mother ○ Sister ○ Brother ○ Other _____

Do you use tobacco or tobacco products? Yes No Any controlled substances? Yes No

How would you rate your stress on the job, or in school, if a student? ○ Average ○ Below Average ○ Above Average ○ Very High

How would you rate your food choices? ○ Mostly Healthy ○ Sometimes Healthy ○ Not Healthy ○ Not sure
Do you take multivitamins regularly? Yes No

How often do you exercise? ○ Regularly ○ Every once in awhile ○ Rarely ○ Would like to, but find it hard to do

Current height: _____ Current weight _____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other
If yes, please explain: _____

Do you have, or have you had, any of the following diseases/conditions?

☐ Heart (Surgery, Disease, Attack)	☐ Stroke	☐ Asthma	☐ Blood Transfusion
☐ Chest Pain	☐ Diet (Special/Restricted)	☐ Hay Fever	☐ Hemophilia
☐ Congenital Heart Disorder	☐ Artificial Joints (Hip, Knee, etc.)	☐ Allergies or Hives	☐ Sickle Cell Disease
☐ Heart Murmur Disease	☐ Kidney Trouble	☐ Sinus Trouble	☐ Leukemia
☐ High Blood Pressure	☐ Frequent Urination	☐ Radiation Therapy	☐ Bruise Easily
☐ Low Blood Pressure	☐ Ulcers	☐ Chemotherapy	☐ Liver Disease
☐ Mitral Valve Prolapse	☐ Diabetes	☐ Tumors	☐ Yellow Jaundice
☐ Artificial Heart Valve	☐ Thyroid Disease	☐ Hepatitis A (Infectious)	☐ Stomach/Intestinal
☐ Heart Pacemaker	☐ Hypoglycemia	☐ Hepatitis B/C/D	☐ Neurological Disorders
☐ Rheumatic Fever	☐ Contact Lenses	☐ Venereal Disease	☐ Alzheimer's
☐ Arthritis/Rheumatism	☐ Glaucoma	☐ AIDS	☐ Epilepsy or Seizures
☐ Cortisone Medicine	☐ Chronic Cough	☐ HIV Positive	☐ Fainting or Dizzy Spells
☐ Swelling of Limbs	☐ Tuberculosis	☐ Cold Sores/Fever Blisters	☐ Nervous/Anxious
☐ Recent Weight Loss	☐ Emphysema	☐ Anemia	☐ Psychiatric Care

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

_____

DR. COMMENTS: _____

ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

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 my (patient's) medical status.

_____ _____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN (Please circle one) DATE

ACCOUNT INFORMATION:

Name of person responsible for your account _____ Relationship to patient _____

Address _____Home phone _____ Cell#/Work #_____

Driver's License # _____ Date of Birth _____ Social Security # _____

Employer _____ Insurance Company _____ Group# _____

Policy ID #_____ Insurance Phone # _____

Secondary Insurance _____

_____

FEES • PAYMENTS • INSURANCE

Payment of fees and co-payments are due and payable at the time services are rendered unless financial arrangements have been made. A finance charge will be added to any balance over 90 days. . Please note that patients are responsible for all fees charged for services in our office, regardless if their insurance denies a claim or if they have exceeded their maximum benefits for their benefit year.

We accept cash, personal checks, money orders, VISA, MasterCard and Discover. A 5% courtesy discount is available for pre-paying dental treatment over $500. We also offer outside interest-free financing plans for the funding of major cases. For major restorative or cosmetic appointments, a down payment is required.

CANCELLATION/NO SHOWS: As a courtesy to all patients, we require a 48-hour notice if you are unable to make your appointment. **A $75 charge may be applied to your account per missed appointment, if sufficient notice is not received.**

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I have read all the insurance and financial policies described above. I agree to be responsible for payment of all services rendered on my behalf or on my dependents' behalf, regardless of what my insurance may do. I also understand that payment /co-payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2 % late charge (18% APR) may be added to my account. I further agree to assign any/all insurance benefits payable to me to the dental office of Dr. Ronald R. Morin. Should further information be needed in the course of my treatment, you have my permission to ask the respective health care provider or agency, who may release such information to you.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN (IF MINOR) DATE

CONSENT FOR TREATMENT

I hereby authorize Dr. Morin or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of Patient _____'s dental needs. Upon such diagnosis, I authorize Dr. Morin to perform all recommended treatment mutually agreed by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

_____ _____ _____

SIGNATURE DATE WITNESS

_____ _____

PARENT/RESPONSIBLE PARTY SIGNATURE RELATIONSHIP TO PATIENT