WELCOME - BERNARD W. MURRAY, D.D.S, LTD.

DATE: ____________________

1 Patient Information (CONFIDENTIAL)

Name (Ms., Mrs., Mr.) ____________________

Address ____________________

Home Phone ____________________ Cell Phone ____________________

Social Security # ____________________ Birthdate ____________________

Patient's or (if minor) Parent's Name ____________________

Employer ____________________ Work Phone ____________________

If Patient is a Student, Name of School/College ____________________

Referred By ____________________

General Dentist ____________________

2 Dental Insurance Information

Name of Insured ____________________

Relationship to Patient ____________ Birthdate ________ Social Security # ____________

Name of Employer ____________________ Work Phone ____________

Address of Employer ____________________ City ____________ State ______ Zip ______

Insurance Company ____________________

Group # ____________ Union or Local # ____________________

Ins. Co. Address ____________________ City ____________ State ______ Zip ______

Insurance Company Phone # ____________________

DO YOU HAVE SECONDARY DENTAL INSURANCE?

❑ Yes ❑ No IF YES, COMPLETE THE FOLLOWING

Name of Insured ____________________

Relationship to Patient ____________ Birthdate ________ Social Security # ____________

Name of Employer ____________________ Work Phone ____________

Address of Employer ____________________ City ____________ State ______ Zip ______

Insurance Company ____________________

Group # ____________ Union or Local # ____________________

Ins. Co. Address ____________________ City ____________ State ______ Zip ______

Insurance Company Phone # ____________________

Medical History

Do you have a personal physician? ❑ Yes ❑ No
Physician's Name:________________ Phone #: (____)________
Last Visit Date: ________________
In the event of an emergency, is there someone who lives near you that we should contact?
His/Her Name: ________________
Relation:__________ Wk #: (____)__________ Hm #: (____)__________

	Yes	No
1. Are you under medical treatment now?	❑	❑
If yes, please explain: ________________		
2. Have you ever been hospitalized for any surgical operation or serious illness?	❑	❑
If yes, please explain: ________________		
3. Are you taking any medication(s) including non-prescription medicine or herbs?	❑	❑
If yes, please list amount and frequency: ________________		
4. Are you taking any hormones?	❑	❑
Are you allergic to :		
Local Anesthetics (e.g. novocaine)	❑	❑
Penicillin, Amoxicillin, or other Antibiotics	❑	❑
Sulfa Drugs	❑	❑
Aspirin	❑	❑
Latex	❑	❑
Vinyl	❑	❑
Other	❑	❑
If other please list: ________________		
5. Do you smoke or chew tobacco?	❑	❑
If yes, please list amount and frequency: ________________		
6. Do you use alcohol or other drugs?	❑	❑
If yes, please list amount and frequency: ________________		
7. Women Only:		
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing	❑	❑
c) Are you taking birth control pills	❑	❑
If yes, please list: ________________		

8. Do you have or have you had any of the following?

	Yes	No
Heart Disease	❑	❑
Heart Attack	❑	❑
Angina	❑	❑
Stroke	❑	❑
Heart Murmur	❑	❑
Rheumatic Fever	❑	❑
Previous Cardiac Endocarditis	❑	❑
Mitral Valve Prolapse	❑	❑
Prosthetic Cardiac Valve, Conduits, Shunts	❑	❑
Hypertrophic Cardiomyopathy	❑	❑
Coronary Artery Bypass Graft Surgery	❑	❑
Cardiac Pacemaker or Defibrillator	❑	❑
Congenital Heart Disease	❑	❑
Low or High Blood Pressure	❑	❑
Swollen Ankles	❑	❑
Lung Problems, Emphysema	❑	❑
Tuberculosis	❑	❑
Asthma	❑	❑
Hay Fever or Allergies	❑	❑
Sinus Trouble	❑	❑
Fainting/Seizures	❑	❑
Cancer	❑	❑
Radiation Therapy	❑	❑
Chemotherapy	❑	❑
Diabetes	❑	❑
Kidney Diseases	❑	❑
Stomach Troubles/Ulcers	❑	❑
Anemia	❑	❑
Hemophilia	❑	❑
Liver Disease	❑	❑
Hepatitis, Jaundice	❑	❑
AIDS or HIV Infection	❑	❑
Thyroid/Endocrine Disorder	❑	❑
Arthritis or Rheumatism	❑	❑
Prosthesis... hips, knees, etc.	❑	❑
Venereal Disease (Syphilis, Gonorrhea)	❑	❑
Chemical Dependency Treatment	❑	❑
Other Health Conditions:	❑	❑

If yes to any above, please explain in detail... ______________________________

____

____

____

____

4 *Dental History*

	Question	YES	NO
1.	Do your gums bleed while brushing or flossing?	❑	❑
2.	Are your teeth sensitive to hot or cold liquids/foods?	❑	❑
3.	Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑
4.	Do you feel pain in any of your teeth?	❑	❑
5.	Have you had any head, neck or jaw injuries?	❑	❑
6.	Have you ever 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?	❑	❑
7.	Do you have frequent headaches?	❑	❑
8.	Do you clench or grind your teeth?	❑	❑
9.	Have you ever had any complications with extractions?	❑	❑
10.	Do you have dental implants?	❑	❑
11.	Have you ever had orthodontic work?	❑	❑
12.	Have you had periodontal treatment?	❑	❑

When? ________________ Where? ________________

13. How often do you have your teeth cleaned? ______________________________

____

14. How often do you brush? ____________________ Floss? ____________________

5 *Authorization and Release*

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.

X ____
Signature of patient or parent if minor