

Welcome to our Practice

Daniel P. Sullivan, DDS

James M. Maguire, DMD

*The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain optimal oral health.*

Please complete this form completely.

Today's Date: _____

Referred by: _____

PATIENT INFORMATION

Name: _____
Last First Mi Mr. Ms. Mrs. Dr.

I prefer to be called: _____ Male Female

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

Home Address: _____
Apt/ Condo#

City State Zip

Single Married Partnered Divorced/Seperated
 Widowed

E-mail address: _____

Home #: _____ Cell#: _____

Work#: _____ Ext: _____ DL# _____

Employer: _____

Employer Address: _____

Occupation: _____

Where & when are best times to reach you? _____

Other family members seen by us: _____

Previous/ Present Dentist: _____

Student Status

Full Time or Partime _____

Name and Location of School: _____

Person Responsible for account:

Name: _____
Last First Mi Mr. Ms. Mrs. Dr.

Home Address: _____
Apt/ Condo#

City State Zip

Home #: _____ Cell#: _____

SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Wk#: _____

Birthdate: ___/___/___ SS# _____

Emergency Contact Information:

His/Her Name: _____

Hm#: _____ Wk#: _____

Relation: _____

INSURANCE INFORMATION

Primary Dental Insurance

Insurance co. Name: _____

Insurance co. Address: _____

Ins. Telephone #: _____

Plan Group #: _____

Insured's ID# or SS#: _____

Insured's Name: _____

Relation: _____ DOB: _____

Insured's Employer: _____

Employer Address: _____

Primary Medical Insurance

Insurance co. Name: _____

Insurance co. Address: _____

Ins. Telephone #: _____

Plan Group #: _____

Insured's ID# or SS#: _____

Insured's Name: _____

Relation: _____ DOB: _____

Insured's Employer: _____

Employer Address: _____

***Please let us know if there is any secondary coverage so we can provide you with an additional form.**

Payment is due in full at the time of treatment.

If this office accepts my insurance, I understand that I am responsible for payment of services rendered including any co-payment and/or deductible that my insurance does not cover. I hereby authorize payment be made directly to Warren Oral and Maxillofacial Surgery. I understand I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my Insurance Company.

Signature _____ Date _____

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MEDICAL HISTORY

****Very important: Please be specific and inform the office when information needs to be updated! ****

Do you have a personal physician? yes no

Physician's Name: _____
Phone #: _____
Date of last office visit: _____

Pharmacy Name: _____
Tel #: _____
Location: _____

Your current physical health is: Good Fair Poor

Medical conditions you are currently being treated for:

**Current Listing of Medications:
(Prescription and over the counter)**

Do you smoke or use tobacco in any other form? yes no
Have you had any metal rods, pins or implants? yes no

For Women: Are you taking Birth Control? yes no
Are you pregnant? yes no
Are you nursing? yes no

Have you ever had any of the following diseases or medical problems?(Circle)

- | | |
|------------------------------------|---------------------------|
| Y N Abnormal Bleeding / Hemophilia | Y N Herpes |
| Y N AIDS | Y N High Blood Pressure |
| Y N Alcohol/Drug Abuse | Y N HIV |
| Y N Anemia | Y N Hospitalized |
| Y N Arthritis | Y N Kidney Problems |
| Y N Artificial Bones/Joints/Valves | Y N Liver Disease |
| Y N Asthma | Y N Low Blood Pressure |
| Y N Blood Transfusion | Y N Lupus |
| Y N Cancer / Chemotherapy | Y N Mitral Valve Prolapse |
| Y N Colitis | Y N Pacemaker |
| Y N Congenital Heart Defect | Y N Psychiatric Problems |
| Y N Diabetes | Y N Radiation Treatment |
| Y N Difficulty Breathing | Y N Rheumatic Fever |
| Y N Emphysema | Y N Seizures |
| Y N Epilepsy | Y N Shingles |
| Y N Fainting Spells | Y N Sickle Cell / Traits |
| Y N Frequent Headaches | Y N Sinus Problems |
| Y N Glaucoma | Y N Stroke |
| Y N Hay Fever | Y N Thyroid Problem |
| Y N Heart Attack / Surgery | Y N Tuberculosis(TB) |
| Y N Heart Murmur | Y N Ulcers |
| Y N Hepatitis | Y N Venereal Disease |

Please list all surgeries/dates: _____

Are you allergic to any of the following? (Circle Y or N)

- | | | |
|-------------|--------------------|------------------------|
| Y N Aspirin | Y N Erythromycin | Y N Penicillin |
| Y N Codeine | Y N Jewelry/Metals | Y N Tetracycline |
| Y N Other | Y N Latex | Y N Dental Anesthetics |

Please list any other drugs/materials that you are allergic to:

DENTAL HISTORY

General Dentist: _____
Phone#: _____
Date of Last Office Visit: _____

Why have you come to our office today? _____

Are you currently in pain? _____

Do you require antibiotics before dental treatment? yes no

Your current dental Health is: Good Fair Poor

Have you ever had a serious/difficult problem associated with any previous dental work? yes no
If yes, please explain:

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)? yes no

Dou you still have your wisdom teeth? yes no

IS THERE ANY OTHER INFORMATION WE NEED TO KNOW PRIOR TO COMPLETING THE NECESSARY TREATMENT? _____

I understand that the following information that I have given today 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/dental status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature _____ Date _____

OFFICE USE ONLY:

I verbally reviewed the medical / dental information with the patient named herein.

Initials: _____ Date: _____

Doctors Comments: _____

