MORRISON DENTAL ASSOCIATES
www.mdadental.com

Welcome. The benefits of a happy healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate the better we can care for you.

Name _____
Last First Middle

Date of Birth _____ Social Security Number _____

____ Married ____ Single ____ Divorced ____ Widowed

Physical Address _____ Apt. # _____

City _____ State _____ Zip _____

Mailing Address (if different) _____

City _____ State _____ Zip _____

Home Phone (_____)_____ Cell Phone (_____)_____

Work Phone (_____)_____ Email Address _____

Employer _____ Position _____

Employer Address _____

City _____ State _____ Zip _____

In the event of an emergency who should we contact? _____

Relationship _____ Phone Number _____

If you wish to file dental insurance or Medicaid please tell the receptionist so we can obtain the information necessary to file for you.

The undersigned understands that insurance or Medicaid coverage does not relieve him/her of the responsibility of payment of the entire account if third party payment is not received. Estimates given by our staff are not a guarantee of the insurance or Medicaid payments as these third parties will not guarantee payments until a claim is received. Estimates are based on information we have at the time regarding your coverage. The undersigned is responsible for the payment of services rendered in addition to the head of household. If the patient is a minor BOTH parents are responsible. If the undersigned is not the patient it is understood that the patient is also responsible for payment of services provided for him/her.

In event of non-payment resulting in default of the account should Morrison Dental Associates, PC refer this account to an attorney, I agree to pay and indemnify Morrison Dental Associates, PC against legal cost and charges including, but not limited to, reasonable attorney's fees, court cost and disbursements. I further grant permission to release information contained on this information sheet to any attorney in order to collect the amount due. Interest shall accrue on the account at the rate of 1.5% per month, 18% annum, on the unpaid balance. **Payment in-full is due at the time of service**. Any account not paid at the time of service is due in-full within thirty (30) days of services. If account is not paid at the time of service, Morrison Dental Associates, PC is authorized to obtain a report from a credit reporting agency regarding my credit history.

PLEASE GIVE THE RECEPTIONIST A PHOTO IDENTIFICATION CARD.

_____

Patient / Parent or Guardian Date

Social Security Number _____

***** Member Equifax Credit Reporting Services *****

As required by law, you are hereby notified that a negative credit report reflecting on your credit record may be submitted to a credit reporting agency if you fail to fulfill the terms of your credit obligations.

Patient's Medical History Information

Name _____ Date of Birth _____

Why have you come to the dentist today? _____

Last visit to the dentist _____ Who was your previous dentist? _____

Do you have a physician? Yes ____ No ____

May we have permission to contact your physician if necessary? Yes ____ No ____

Physician's Name _____ Phone Number _____

Are you currently under the care of a physician? Yes ____ No ____ If yes, explain _____

_____

Please list all medications you are currently taking _____

_____

For females – Are you pregnant? Yes ____ No ____ Week # _____

OB/GYN's Name _____ Phone Number _____

Have you had any serious medical problems in the past 5 years? Yes ____ No ____

Please explain _____

Are you **ALLERGIC** to any of the following? **PLEASE CIRCLE**

Y	N	Penicillin / Amoxicillin	Y	N	Aspirin
Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Sulfa Drugs	Y	N	Codeine
Y	N	Dental Anesthetics	Y	N	Latex
Y	N	Other			

Please list _____

Do you have any of the following disease or medical problems? **PLEASE CIRCLE**

Y	N	Heart Attack / Stroke	Y	N	Cancer / Chemotherapy
Y	N	Heart Murmur / Rheumatic Fever	Y	N	HIV+ / AIDS
Y	N	Heart Surgery / Pace Maker	Y	N	Shingles
Y	N	Hepatitis	Y	N	Kidney Problems
Y	N	Anemia	Y	N	Sinus Problems
Y	N	High Blood Pressure	Y	N	Fever Blisters
Y	N	Low Blood Pressure	Y	N	Psychiatric Problems
Y	N	Epilepsy / Seizures / Fainting	Y	N	Diabetes
Y	N	Drug / Alcohol Abuse	Y	N	Tuberculosis TB
Y	N	Hemophilia / Abnormal Bleeding	Y	N	Sickle Cell Disease
Y	N	Severe Headaches	Y	N	Other

If yes on Other, please explain _____

MEDICATION WARNING

Research has revealed that having certain dental procedures after taking Bisphosphonate drugs can result in severe side effects. The following drugs are commonly used to treat osteoporosis, certain types of cancer and other conditions that feature bone fragility. If you have ever been treated for any of these conditions but are not sure if you have ever taken any of the medications listed below, please let the doctor know.

Y	N	Actonel	Y	N	Zometa
Y	N	Aredia	Y	N	Bonefos
Y	N	Boniva	Y	N	Ostac
Y	N	Fosamax	Y	N	Skelid
Y	N	Didronel			

I the undersigned, do hereby authorize Morrison Dental Associates, PC to exam and treat the patient as deemed necessary by the dentist. If the undersigned is not the patient, he/she assumes all responsibility for the accurateness of the medical and dental information furnished on this form. I further affirm that the medical and dental information is correct and the patient does not have any communicable disease which would be infectious to those providing services for him/her or others coming in contact with the patient in the office. This authorization is good for two years.

_____

Patient or Guardian Date