Date: ______________________

PATIENT REGISTRATION

First Name: _________________________ Last Name: _________________________Middle Initial: ____

Preferred Name: _____________________

Patient is: □ Responsible Party □ Policy Holder

Patient Information

Address: ____

City: ________________________________ State: _________ Zip Code: _________

Cell/Home Phone: ___________________ Work Phone: _________________

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: ________________ Social Security #:_________________________

E-mail:____ □ I would like to receive email correspondences

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Preferred Pharmacy: ___________________________

Responsible Party: (if someone other than the patient)

First Name: ___________________________ Last Name: ________________________________

Address: ____

City: ________________________________ State: _________ Zip Code: _________

Phone: ___________________

○ Responsible Party is Policy Holder for Patient

Primary Insurance Information:

Name of Insured: __________________________ Relationship to Insured: ○Self ○Spouse ○Child ○Other

Employer: _______________________________ Insurance Company: _____________________________

Insured S.S. or I.D. #: ______________________ Insured Birth date: ____________________________

Is There Secondary Insurance? ○Yes ○No

Whom may we thank for referring you? ____

In case of emergency who should be notified? _______________**Phone** (___) _________________________

Dental History

Reason for Today's Visit ____

Date of last dental care ___________________________

Former Dentist ______________________________ **Date of last dental x-rays** _________________________

Check if you have had any of the following:

Bad Breath ○Yes ○No	Grinding Teeth ○Yes ○No	Sensitivity to hot ○Yes ○No
Bleeding gums ○Yes ○No	Loose teeth or fillings ○Yes ○No	Sensitivity when biting ○Yes ○No
Sensitivity to sweets ○Yes ○No	Sensitivity to cold ○Yes ○No	Clicking or popping jaw ○Yes ○No
Periodontal treatment ○Yes ○No	Currently in pain ○Yes ○No	

How often do you brush? _________________ **How often do you floss?** _________________________

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Have you had a serious illness, operation or been hospitalized in the past 2 years? If yes, please explain____________
____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: ______________________________________
Are you on Coumadin or any blood thinners? Yes No If yes, please explain: ______________________________________
Are you taking any other medications, pills, or drugs? Yes No If yes, please explain ____
____

Are you on a special diet? Yes No
Do you use tobacco? Yes No
Do you use controlled substances? Yes No

Women: **Are you Pregnant?** Yes No **Taking oral contraceptives?** Yes No **Nursing?** Yes No

Are you allergic to any of the following?

o Aspirin o Penicillin o Codeine o Acrylic o Metal o Latex o Local Anesthetics o Sulfa Drugs

Other If yes, please explain: ____

Do you have, or have you had, any of the following:

□ **AIDS/HIV Positive**	□ **Convulsion**	□ **Irregular Heartbeat**
□ **Anaphylaxis**	□ **Cortisone Medicine**	□ **Kidney Problems**
□ **Anemia**	□ **Diabetes**	□ **Leukemia**
□ **Angina**	□ **Drug Addiction**	□ **Low Blood Pressure**
□ **Arthritis/Gout**	□ **Easily Winded**	□ **Osteoporosis**
□ **Artificial Heart Valve**	□ **Epilepsy or Seizures**	□ **Psychiatric Care**
□ **Artificial Joint**	□ **Excessive Bleeding**	□ **Radiation Treatments**
□ **Asthma**	□ **Frequent Headaches**	□ **Recent Weight Loss**
□ **Blood Disease**	□ **Heart Pacemaker**	□ **Renal Dialysis**
□ **Breathing Problem**	□ **Heart Trouble/Disease**	□ **Shingles**
□ **Bruise Easily**	□ **Hemophilia**	□ **Sickle Cell Disease**
□ **Cancer**	□ **Hepatitis A**	□ **Sinus Trouble**
□ **Chemotherapy**	□ **Hepatitis B or C**	□ **Stroke**
□ **Chest Pains**	□ **High Blood Pressure**	□ **Swelling of Limbs**
□ **Cold Sores/Fever Blisters**	□ **Hypoglycemia**	□ **Thyroid Disease**
□ **Congenital Heart Disorder**	□ **COVID-19 Date: If Yes**_________	**Vaccine Yes/No Date:**______

Have you ever had any serious illness not listed above? If yes, please explain: ____

____

To the best of my knowledge, the questions on this form have been accurately answered. 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 medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____ DATE _________________

ACKNOWLEDGMENT OF PRIVACY NOTICE, CONSENT FOR TREATMENT, & PHOTO RELEASE

I have read a copy of this office's notice of privacy practices, and give consent for treatment of any services deemed advisable by the doctor.

Signature____ Date _________________________

PATIENT FINANCIAL RESPONSIBILITY AND AUTHORIZATION

Thank you for choosing Murphy Family Dentistry for your dental needs. We are committed to providing you with the highest quality of dental care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

PATIENT'S RESPONSIBILITY:

- As a patient, (or patient's guardian, if a minor) it is in your best interest to understand your insurance plan benefits & your responsibility to be aware of any covered and non-covered benefits, authorization requirements and costs, such as deductibles, co-insurance, and co-pays. If you are not familiar with your plan coverage, we recommend that you contact your carrier directly (the phone number should be on your insurance card)
- We will bill your insurance. However, the patient is required to provide the most correct and updated information regarding your insurance.
- Patients are responsible for payments of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
- To promptly pay any patient responsibility indicated by their insurance carrier. A late fee will be added on unpaid patient balances to their account over 90 days of receipt of insurance payments.
- We reserve the right to collect any payment for services rendered before submitting to insurance.

Financial Policy acknowledgement:
I have read & understood the above financial policy: I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered. I understand that payments can be made by cash, or by credit or debit card or on our website: www.josephmurphydental.com. I agree that if my account is referred to a collection agency, I will be responsible for costs of collection on my account.

Signature____ Date ________________________