Welcome to our office! This information will help us take care of you.

MURMANN DENTAL HEALTH

About You

Name: _____ ____ _____ _____
First MI Last Preferred Name

Address: _____

Phone Numbers: (____)_____ (____)_____ (____)_____
Cell Work Home

E-mail address: _____ Social security # _____

How would you like to be reminded about your dental appointment? _____

Date of Birth: _____ Age: _____ Gender: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____ Employer: _____

Your Health

Are you in good health? _____ Has there been a change in your health in the last year? _____

When did you last see a doctor? _____ What was done? _____

Have you been hospitalized in the last 5 years? _____ If so, for what? _____

Are you currently under the care of a physician? _____ If so, for what? _____

Your Medications

NAME OF MEDICATION	DOSE	WHEN TAKEN	WHAT MEDICATION IS FOR

Please mark anything you have had **in the Past with a P** or **Currently with a C**.

__ Allergies
__ Allergy to Amoxicillin
__ Allergy to Aspirin
__ Allergy to Keflex
__ Allergy to Penicillin
__ Allergy to Sulfa
__ Allergy to Zithromax
__ Anemia
__ Angina
__ Arrhythmias
__ Artificial Heart Valve
__ Asthma
__ Arthritis
__ Autism
__ Autoimmune Disease
__ Bleeding Problem
__ Blood Disease
__ Blood Thinner
__ Bone Density Medication
__ Cancer
__ Coronary Artery Surgery
__ Depression/Anxiety
__ Diabetes
__ Dizziness
__ Dry Mouth/Eyes
__ Epilepsy/Seizures
__ GLP-1/Ozempic Meds
__ Fainting
__ Head Injuries
__ Heart Attack
__ Heart Disease/Failure
__ Heart Murmur
__ Hepatitis
__ High Blood Pressure
__ HIV
__ Humanpapillomavirus (HPV)
__ Infective Endocarditis
__ Jaundice
__ Kidney Disease
__ Liver Disease
__ Low Blood Pressure
__ Lung/Breathing Problems
__ Mental Health Disorder
__ Migraines
__ Neurological Disorder
__ Organ Transplant
__ Osteoporosis
__ Pacemaker
__ Pre-Medication
__ Pregnancy
__ Prosthetic Joint Replacement
__ Radiation Treatment
__ Reflux/GERD
__ Sexually Transmitted Disease
__ Sinus Problem
__ Stomach Problem
__ Stroke
__ Thyroid Problem
__ Tuberculosis
__ Ulcer

For Women Only

Are you taking birth control pills? _____ Are you aware antibiotic stop BCP from working?_____

Are you pregnant? _____ If so, when is the due date? _____ Any nausea? _____

Are you nursing? _____

Any Other Health Issues or Allergies?

Your Sleep Quality

Do you snore? _____ Have you been diagnosed with sleep apnea?_____

Do you often feel tired during the day? _____ Why? _____

Do you wake up with a headache? _____ Any problems with your jaws? _____

Do you grind your teeth? _____ Clench your teeth?_____ Did you use to do either? _____

Do you have a night guard? _____ How often do you wear it? _____

Your Orthodontic History

Did you have braces? _____ If so, for how long? _____

Do you have retainers? _____ If so, what kind? _____

How often do you wear them? _____

Your Dental History

Any history of complications with or after dental treatment? _____

Have you had any gum problems or gum treatments? _____

When was your last visit to a dentist? _____ What was done? _____

What was your last dentist's name and city? _____

Why did you decide to go to a new office? _____

How did you decide to come to our office? _____

Any Dental Problems

How can we help you today? _____

Are any teeth causing you pain? _____ Where? _____ How long? _____

Are any teeth sensitive to hot? _____ Where? _____ How long? _____

Are any teeth sensitive to cold? _____ Where? _____ How long? _____

Do your gums bleed when you brush? _____ When you floss? _____ Where? _____

Are any of your teeth loose? _____ If so, where? _____

Is there anything you want changed about your mouth, teeth or smile? _____

_____

Your Dental Home Care

How often do you brush your teeth? _____ What kind of toothbrush? _____

Have you been told you brush too hard? _____ How often do you floss? _____

Do you use any other dental home care products? _____

Do you smoke or use tobacco? _____ How much? _____

Notice of Privacy Practices Acknowledgement & Patient Consent to Disclosure

Please Initial that your have been offered a copy, and consent to disclosure of your information to your insurance company, and any other dental offices that require information to further your treatment.

_____ Yes, I have been offered a copy of the Notice of Privacy Practices, and consent to disclosure.
Initial

Our Financial Policy

INSURANCE
Our office is committed to helping our patients maximize their benefits. As a service to our patients, we will bill insurance companies for services. Your portion must be paid at the time of service. The quality of insurance policies varies greatly; therefore we can estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts.

PAYMENT
Anything not covered by insurance is due at the time of service. We offer several payment options: Cash, Checks, Visa, MasterCard, and Discover. The adult accompanying a minor is responsible for payment of the service.

MISSED APPOINTMENTS
Once an appointment has been made, please remember that this time has been reserved specifically for you. If we are not notified 24 hours or more before your appointment, you will be charged the current missed appointment fee.

Please Initial: _____

SERVICE CHARGES
We will charge $45.00 for returned checks.

I understand and agree to this Financial Policy. **Please Initial**: _____

Signature of patient/responsible party _____ Date _____

Relationship of signer to the patient: ☐ Self ☐ Parent ☐ Other _____