



Thank you for choosing Mount Vernon Dental. To help us meet your dental care needs, please fill out **BOTH SIDES** of this form completely in blue or black ink. If you have any questions or need assistance, please ask us and we will be happy to help.

1) Patient Information (Confidential)

Today's Date _____

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

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

Employer _____ Work Phone (____) _____

E-Mail _____

Check Appropriate Box: Minor Single Married Separated Divorced Widowed

Preferred Pronouns (Optional) _____

If Student, Name of School/College _____ City _____ State _____

Spouse or Parent/Guardian's Name _____

Person to Contact in Case of Emergency _____ Phone (____) _____

How did you hear about our office? _____

2) Responsible Party Check here if same as above

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

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

E-Mail _____

Birthdate _____ SS# _____

Employer _____ Work Phone (____) _____

Is this Person Currently a Patient in our Office? Yes No

3) Payment Information

For your convenience, we offer the following methods of payment. Please check the option you prefer.

Please note, payment is due at the time of services

Cash Personal Check Credit Card I Wish to Discuss Payment Options

4) Insurance Information

Insurance Company _____

(Check here if same as responsible party)

Name of Employer _____ Work Phone (____) _____

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____

5) Secondary Insurance Information (If applicable)

Insurance Company _____

(Check here if same as responsible party)

Name of Employer _____ Work Phone (____) _____

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____

Patient Medical History

Physician _____ Office Phone () _____ Date of Last Exam _____

Check ALL that apply

Are you under active medical treatment for a particular problem? Yes

Have you been hospitalized for any surgery or serious illness?

Do you take any medications? Please list ALL (including non-prescription, herbals, vitamins, etc.):

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____

9 _____

10 _____

11 _____

12 _____

13 _____

Have you *EVER* taken Bisphosphonates (i.e. Fosamax, Boniva)?

Do you use tobacco?

Cigarettes/Cigars Chewing Vaping

Do you have any allergies to the following: Yes

Local anesthetics

Penicillin

Other Antibiotics

Sedatives or Barbiturates

Aspirin or Ibuprofen

Codeine or other pain killers

Latex or Rubber Products

Sulfa drugs

Wheat/Gluten

Other / Seasonal Allergies

Food / Flavor Allergies

Have you ever had a joint replaced (i.e. knee, hip, etc)?

Do you have any heart valve defects, repaired or unrepaired?

Do you take blood thinners (Warfarin/Coumadin, Plavix, Aspirin, etc.)?

WOMEN:

Are you pregnant or think you might be pregnant?

Are you nursing?

Are you taking oral contraceptives?

Do you have or have you had any of the following? (Check ALL that apply)

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer	<input type="checkbox"/> Acid Reflux
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Arthritis / Rheumatism
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Chest Pains / Angina	<input type="checkbox"/> Stroke	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Macular Degeneration
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> AIDS or HIV+	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Legally Blind
<input type="checkbox"/> Cardiac Arrhythmia	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Other STD	<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Cardiac Pacemaker	<input type="checkbox"/> Significant Weight Gain / Loss	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Celiac Disease
<input type="checkbox"/> Heart Murmur / Mitral Valve Prolapse	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Chronic Sinus Problems
<input type="checkbox"/> Frequently Tired / Shortness of Breath	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Deaf / Hard of Hearing
<input type="checkbox"/> Swollen Ankles	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Stomach Trouble / Ulcers	<input type="checkbox"/> Other:
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease	<input type="checkbox"/> Fainting / Seizures / Convulsions	<input type="checkbox"/> Anemia	<input type="checkbox"/> *****NONE*****

Patient Dental History

Previous Dentist _____ Location _____ Office Phone () _____ Date of Last Exam _____

Do your gums bleed while brushing or flossing? <input type="checkbox"/> Yes	Do you clench or grind your teeth? <input type="checkbox"/> Yes
Are your teeth sensitive to hot or cold liquids/food? <input type="checkbox"/>	Do you bite your lips or tongue frequently? <input type="checkbox"/>
Are your teeth sensitive to sweet or sour liquids/food? <input type="checkbox"/>	Have you had any difficult extractions in the past? <input type="checkbox"/>
Do you feel any pain in any of your teeth? <input type="checkbox"/>	Have you ever had prolonged bleeding following an extraction? <input type="checkbox"/>
Do you have any sores or lumps in or near your mouth? <input type="checkbox"/>	Have you ever had orthodontics (Braces)? <input type="checkbox"/>
Have you had any head, neck, or jaw injuries? <input type="checkbox"/>	Do you wear dentures or partial dentures? <input type="checkbox"/>
Have you experienced any problems in your jaw? <input type="checkbox"/> (Clicking, Pain, Difficulty opening/closing, Difficulty chewing)	Is there anything you'd like to change about your teeth? <input type="checkbox"/>

Authorization and Release

I certify that I have read and understand the above information and 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. I authorize **Mount Vernon Dental - Sprang and Stoycheff, LLC** to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to **Mount Vernon Dental - Sprang and Stoycheff, LLC**, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____ Signature of patient (or parent/guardian if minor)

_____ Date _____ Signature of Doctor