McCarthy Dentistry

405 Second Street • Marietta, Ohio •740-373-6464
www.mytotaldentistry.com

How did you hear about us?

Big Book | ATT Yellowpages | Verizon Yellowpages | Internet | Friend _____ | Family _____ | Other _____

Name: _____
Last First MI Title

Preferred Name: _____ ○ Male ○ Female

Address: _____ City: _____ State: _____ ZIP: _____

SSN: _____ DOB: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____ Preferred Method of Contact: _____

Employer: _____ Occupation: _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated ○ Domestic Partner

Insurance – Primary

Subscriber Name: _____ Relationship to Patient: _____

Subscriber SSN/ID: _____ Subscriber DOB: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Insurance – Secondary

Subscriber Name: _____ Relationship to Patient: _____

Subscriber SSN/ID: _____ Subscriber DOB: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage and assign directly to Today's Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Parent/Guardian Signature: _____

See Reverse Side for Additional Information →

Dental History

Reason for today's visit: _____

_____

Former Dentist: _____

City/State: _____

Date of last dental visit: _____

Date of last dental X-rays: _____

Place a mark on "◯" to indicate if you have had any of the following:

- ◯ Bad breath
- ◯ Bleeding gums
- ◯ Blisters on lips or mouth
- ◯ Burning sensation on tongue
- ◯ Chew on one side of mouth
- ◯ Cigarette, pipe, or cigar smoking
- ◯ Clicking or popping jaw
- ◯ Dry mouth
- ◯ Fingernail biting
- ◯ Food collection between teeth
- ◯ Foreign objects
- ◯ Grinding teeth
- ◯ Gums swollen or tender
- ◯ Jaw pain or tiredness
- ◯ Lip or cheek biting
- ◯ Mouth breathing
- ◯ Mouth pain, brushing
- ◯ Orthodontic treatment
- ◯ Pain around ear
- ◯ Periodontal treatment
- ◯ Sensitivity to cold
- ◯ Sensitivity to heat
- ◯ Sensitivity to sweets
- ◯ Sensitivity when biting
- ◯ Sores or growths in your mouth

How often do you floss? _____

How often do you brush? _____

Medical History

Do you have a personal physician? ◯ Yes ◯ No

Physician's Name: _____ Physician's Phone: _____

Date of last visit: _____

Your current physical health is: ◯ Good ◯ Fair ◯ Poor

Are you currently under the care of a physician? ◯ Yes ◯ No

Please explain: _____

Do you use tobacco in any form? ◯ Yes ◯ No

Are you taking any medications? ◯ Yes ◯ No

Please list each one: _____

Conditions

- ◯ Abnormal Bleeding
- ◯ Alcohol Abuse
- ◯ Allergies
- ◯ Anemia
- ◯ Angina Pectoris
- ◯ Arthritis
- ◯ Artificial Heart Valve
- ◯ Asthma
- ◯ Blood Transfusion
- ◯ Cancer
- ◯ Chemotherapy
- ◯ Colitis
- ◯ Congenital Heart Defect
- ◯ Diabetes
- ◯ Difficulty Breathing
- ◯ Drug Abuse
- ◯ Emphysema
- ◯ Epilepsy
- ◯ Facial Surgery
- ◯ Fainting Spells
- ◯ Fever Blisters
- ◯ Frequent Headaches

Conditions

- ◯ Glaucoma
- ◯ HIV + AIDS
- ◯ Heart Attack
- ◯ Heart Murmur
- ◯ Heart Surgery
- ◯ Hemophilia
- ◯ Hepatitis A
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ High Blood Pressure
- ◯ Joint Replacement
- ◯ Kidney Problems
- ◯ Liver Disease
- ◯ Low Blood Pressure
- ◯ Mitral Valve Prolapse
- ◯ Pace Maker
- ◯ Psychiatric Problems
- ◯ Radiation Therapy
- ◯ Rheumatic Fever
- ◯ Seizures
- ◯ Sexually Transmitted Disease
- ◯ Shingles

Conditions

- ◯ Sickle Cell Disease
- ◯ Sinus Problems
- ◯ Stroke
- ◯ Thyroid Problems
- ◯ Tuberculosis
- ◯ Ulcers

Allergies

- ◯ Aspirin
- ◯ Codeine
- ◯ Dental Anesthetics
- ◯ Erythromycin
- ◯ Jewelry
- ◯ Latex
- ◯ Metals
- ◯ Penicillin
- ◯ Tetracycline

If Female, Please Answer

Are you taking Birth Control pills? ◯ Yes ◯ No

Are you pregnant? ◯ Yes ◯ No

If so, # of weeks: _____

Are you nursing? ◯ Yes ◯ No

Nearest relative not living with you:

Name: _____ Relationship: _____

Address: _____ Phone: _____

I understand that the information that I have given today is a 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 status.

Signature: _____ Date: _____