Murphy's Landing
FAMILY DENTAL

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Phone: (317) 865-8075
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Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Sex ❑ M ❑ F ❑ Married ❑ Divorced ❑ Single ❑ Child
❑ Separated ❑ Partnered for _____ years

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

Employer _____ Employer Phone (____) _____

Spouse or Parent's Name _____ Work Phone (____) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone (____) _____

RESPONSIBLE PARTY

Name of Person _____

Relation to Patient _____

Address _____ E-mail: _____

Birthdate _____ Social Security # _____

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

Currently a patient in our office? ❑ Yes ❑ No

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (____) _____

Insurance Company _____ Group # _____ Union or Local # _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (____) _____

Insurance Company _____ Group # _____ INS Phone (____) _____

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✔) **Y**es or **N**o if you have had problems with any of the following

YN	YN	YN
❑❑ Bad breath	❑❑ Grinding teeth	❑❑ Sensitivity to hot
❑❑ Bleeding gums	❑❑ Loose or broken teeth	❑❑ Sensitivity to sweets/sugar
❑❑ Clicking or popping jaw	❑❑ Periodontal treatment	❑❑ Sensitivity when biting
❑❑ Food collection between teeth	❑❑ Sensitivity to cold	❑❑ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any illnesses or operations? ❑ Yes ❑ No If yes, describe _____

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, give approximate dates _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Apidex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dextenfluramine). ❑ Yes ❑ No

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Check (✔) **Y**es or **N**o if you have or have had any of the following:

YN	YN	YN	YN
❑❑ Anemia	❑❑ Cortisone Treatments	❑❑ Hepatitis	❑❑ Scarlet Fever
❑❑ Arthritis, Rheumatism	❑❑ Cough, Persistent	❑❑ High Blood Pressure	❑❑ Shortness of Breath
❑❑ Artificial Heart Valves	❑❑ Cough up Blood	❑❑ HIV/AIDS	❑❑ Skin Rash
❑❑ Artificial Joints	❑❑ Diabetes	❑❑ Jaw Pain	❑❑ Stroke
❑❑ Asthma	❑❑ Epilepsy	❑❑ Kidney Disease	❑❑ Swollen Feet or Ankles
❑❑ Back Problems	❑❑ Fainting	❑❑ Liver Disease	❑❑ Thyroid Problems
❑❑ Blood Disease	❑❑ Glaucoma	❑❑ Mitral Valve Prolapse	❑❑ Tobacco Habit
❑❑ Cancer	❑❑ Headaches	❑❑ Pacemaker	❑❑ Tonsillitis
❑❑ Chemical Dependency	❑❑ Heart Murmur	❑❑ Radiation Treatment	❑❑ Tuberculosis
❑❑ Chemotherapy	❑❑ Heart Problems	❑❑ Respiratory Disease	❑❑ Ulcer
❑❑ Circulatory Problems	❑❑ Hemophilia	❑❑ Rheumatic Fever	❑❑ Venereal Disease

MEDICAL HISTORY

List medications you are currently taking:

_____

_____

_____

ALLERGIES

❑ Aspirin
❑ Barbituates (Sleeping Pills)
❑ Codeine
❑ Local Anesthetic
❑ Penicillin
❑ Sulfa
❑ Latex _____
❑ Other _____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign payment directly to Murphy's Landing Family Dental.

All insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dental office may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Patient, Parent or Legal Guardian Date

_____ _____
Signature of Treating Dentist / Witness Date

Copayments are due in full at time of treatment unless prior arrangements have been approved