

Musso Family Dentistry
513 W. Centerville Rd., Garland, TX 75041
972-840-8477

Patient Information

Patient Name: _____ Date: _____

Male Female Married Single Child Other _____ MI _____ Birth Date: _____

Social Security #: _____ Driver's License # _____ State _____

Phone (Home): _____ (Work): _____ Ext: _____ Best way to contact: _____

(Cell) _____ E-Mail: _____ Fax: _____

Address: _____

Street

Apartment #

City

State

Zip Code

Health Information

Previous Dentist: _____ Date of Last Dental Visit: _____

On a scale of 1 to 10 with 10 being very severe, what is your level of anxiety while visiting a dental office?

Do you know or have you ever experience pain/discomfort in your jaw joint (TMD/TMJ)? Yes No

Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Allergic/Adverse Reaction To |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Psychiatric/Psychological | Medication or Any Substance, |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Fainting | Care | Please specify: _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pregnancy | _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Growths | Due date: _____ | _____ |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> H. I. V. Positive | <input type="checkbox"/> Respiratory Problems | |
| <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Cold Sores/Fever | <input type="checkbox"/> Heart (Attack, Disease, | <input type="checkbox"/> Rheumatism | |
| Blisters/Herpes | Surgery) | <input type="checkbox"/> Scarlet Fever | |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Smoke/Chew Tobacco | |
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> High Blood Pressure/Low | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Thyroid Problems | |
| <input type="checkbox"/> Diet (Special/Restricted) | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Latex Sensitivity | <input type="checkbox"/> Tumors | |
| | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers | |

- Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

- Are you now under the care of a physician? Yes No

If yes, please explain: _____

• Name of Physician: _____

Phone: _____

- Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

- Are you taking any medications? Please list: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

_____ Date: _____

Signature of Doctor

Cosmetic Information

Is there anything about your smile that you do not like? _____

Are you interested in knowing the options available for a more beautiful smile? _____

What would you like to change the most about the appearance of your teeth? _____

Do you like the appearance of your teeth? _____

Are your teeth as white as you would like them to be? _____

Are all of your teeth in alignment (straight)? _____

Do you have any missing teeth? _____ Are any chipped? _____

Are you interested in having these missing teeth replaced? _____

Are your teeth sensitive to hot or cold? _____

Are you aware of any problems with your gums? _____

Do you pack food between any teeth when chewing? _____

Is your bite comfortable when chewing, biting? _____

Do you have frequent headaches? _____

Do you have any old fillings or dental treatment that you are unhappy with? _____

Is there anything else that you would like us to know? _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another Doctor Dental Office

School Work Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____ Driver's License #: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Name of Insured: _____ Last First MI Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Telephone: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.75% per month (21% per annum) on the unpaid balance will be charged on all accounts exceeding sixty (60) days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services rendered to me or at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Further, I understand and acknowledge that photographs and images of me may be shown to other patients and doctors for treatment and educational purposes and I agree to the same.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____