

MP DENTAL ASSOCIATES  
**PATIENT INFORMATION** (Please Print)

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Marital Status: Single  Married  Divorced  Widowed

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex  M  F SS Number \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ DOB \_\_\_\_\_

Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Email \_\_\_\_\_

How were you referred to or find us? \_\_\_\_\_

Reason for Today's Visit? *Circle as many as applicable:* (Periodontal Disease) (Teeth Grinding) (Jaw Pain) (Loose Teeth) (Sensitivity) (Dry Mouth) (Bad Breath) (Appearance) (Routine Checkup/Cleaning) (Other) \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Name (if different from Patient) \_\_\_\_\_

Subscriber Birthdate \_\_\_\_\_ SS Number \_\_\_\_\_ Relationship \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with the above named Insurance Company and assign directly to MP Dental all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named medical facility may use my healthcare 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 benefits payable for related services. This consent will stay in effect as long as I am a patient with the above named medical facility.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian  
Personal Representative

\_\_\_\_\_  
Please Print Name of Signature of Patient, Parent, Guardian or  
or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

MP DENTAL ASSOCIATES

HEALTH HISTORY

Patient (printed) name \_\_\_\_\_ DOB: \_\_\_\_\_

Please circle "yes or no" to indicate if you have, or have had any of the following:

Table with 6 columns of medical conditions and 'Yes'/'No' response options. Conditions include AIDS/HIV, Anemia, Arthritis, Artificial Heart Valves, Artificial Joints, Asthma, Back Problems, Bleeding Abnormally, Blood Disease, Cancer, Chemical Dependency, Chemotherapy, Circulatory Problems, Congenital Heart Lesion, Cortisone Treatments, Cough, Persistent, Bloody, Diabetes, Emphysema, Epilepsy, Fainting or Dizziness, Glaucoma, Headaches, Heart Murmur, Heart Problems, Hepatitis Type, Herpes, High Blood Pressure, Jaundice, Jaw Pain, Liver Disease, Low Blood Pressure, Mitral Valve Prolapse, Nervous Problems, Pacemaker, Psychiatric Care, Radiation Treatment, Respiratory Disease, Rheumatic Fever, Scarlet Fever, Shortness of breath, Sinus Trouble, Skin Rash, Special Diet, Stroke, Swollen Feet/Ankles, Swollen Neck/Glands, Thyroid Problems, Tonsillitis, Tuberculosis, Tumors, Ulcer, Venereal Disease, Weight Loss, severe.

Do you wear contact lenses? Yes No

Taking Birth Control? Yes No

Are you pregnant? Yes No Due date \_\_\_\_\_ Are you nursing? Yes No

Physician's Name and Phone Number \_\_\_\_\_

MEDICATIONS

List any medications you are currently taking.

Five horizontal lines for listing medications.

ALLERGIES

Circle allergies listed, or others not listed.

List of allergies: Aspirin, Latex, Barbiturates (sleeping pills), Codeine, Local Anesthetic, Iodine, Penicillin, and Other with a blank line.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian if Minor

Relationship to Patient