McManus Family Dentistry, LLC
Dan McManus, DMD

Patient Information

Date: _____

Patient: _____

Home #:_____

Address: _____

Cell #:_____

_____

Birth Date: _____

Employer:_____

Work#: _____
Can we call you at work? ____yes ____no

Social Security #:_____

Referred by:_____

Email:_____

Can we send reminders/appointment confirmations
via **email**? ____yes ____no
via **text**? ____yes ____no

Spouse/Parent Information

Name:_____

Phone#:_____

Address:_____

Employer: _____

Social Security#:_____

Birth Date:_____

Emergency Information (List someone other than in your home)

Name: _____

Phone#:_____

Relationship: _____

Insurance Information

Primary Ins. Co._____

Employer: _____

Member ID#:_____

Employee Name: _____

Group#:_____

Social Security#:_____

Insurance Phone#:_____

Birth Date: _____

Revised 11/07/2017

Health Questionnaire

Name: _____ **Birth Date:** _____

Correct answers to following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate to your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records ONLY and will be considered confidential.

DENTAL

Are you having any discomfort at this time? . . . . . .Yes No

1. Have you ever had any serious trouble associated with previous dental treatment? . . . . . .Yes No
   If so, explain _____
2. Does dental treatment make you nervous? No ____ Slightly ____ Moderately ____ Extremely ____
3. Date of last dental visit _____
4. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No
   If so, when _____
5. How often do you brush? _____
   Toothbrush is: Soft ___ Medium ___ Hard ___
6. Do you or have you ever had any of the following? **(CIRCLE ALL THAT APPLY)**

MOUTH		**TEETH**	
Bleeding, Sore gums	Unpleasant taste/bad breath	Loose teeth	Sensitive to sweets
Burning tongue/lips	Frequent blisters, lips/mouth	Sensitive to hot	Sensitive to cold
Swelling/lumps in mouth	Ortho treatments (braces)	Sensitive to biting	Change in bite
Biting cheeks/lips		Food impaction	Shifting in bite
Clicking/Popping Jaw		Clenching/Grinding	
Difficulty opening or closing jaw		If so, when _____	

7. Do you use the following? **(CIRCLE ALL THAT APPLY)**
   Toothbrush Dental Floss Fluoride Rinse Other _____

MEDICAL

1. Have there been any changes in your general health within the past year . . . . . .Yes No
2. My last physical exam was on _____
3. Are you now under the care of a physician . . . . . Yes No
4. The name and address of my physician is _____
   _____
5. Have you had any serious illness within the past 5 years . . . . . .Yes No
   If so, what illness _____
6. Have you been hospitalized or had an operation within the past 5 years . . . . . Yes No
7. Do you have or have you ever had any of the following diseases or problems
   a. Rheumatic fever or rheumatic heart disease . . . . . .Yes No
   b. Congenital Heart Disease . . . . . .Yes No
   c. Cardiovascular Disease **(CIRLCE ALL THAT APPLY)** . . . . . .Yes No
      Heart Trouble Heart Attack Heart Murmur Coronary Insufficiency
      Coronary Occlusion High/Low blood pressure Arteriosclerosis Stroke
      i. Do you have pain in chest upon exertion . . . . . .Yes No
      ii. Are you ever short of breath after mild exercise . . . . . Yes No
      iii. Do you ankles swell . . . . . .Yes No
      iv. Do you get short of breath when you lie down, or do you require extra pillows when you sleep . . . Yes No
   d. Artificial or replacement valves . . . . . Yes No
   e. Pacemaker . . . . . .Yes No
   f. Allergy . . . . . Yes No
   g. Sinus Trouble . . . . . Yes No
   h. Asthma or Hay Fever . . . . . Yes No
   i. Hives or skin rash . . . . . .Yes No
   j. Fainting spells or seizures . . . . . .Yes No
   k. Diabetes . . . . . .Yes No
      i. Do you have to urinate (pass water) more than 6 times a day . . . . . .Yes No
      ii. Are you thirsty much of the time . . . . . .Yes No
      iii. Does your mouth frequently become dry . . . . . Yes No
   l. Hepatitis, jaundice or liver disease . . . . . Yes No
   m. Taking Biphosphonates (FOSAMAX, BONIVA, ACTONEL etc..) currently or in the past . . . . . Yes No

n. Arthritis or inflammatory rheumatism . . . . . .Yes No
o. Artificial or replacement joints, prosthetic . . . . . .Yes No
p. Digestive system-ulcers or stomach disorders (colitis) . . . . . .Yes No
q. Kidney trouble . . . . . .Yes No
r. Tuberculosis . . . . . Yes No
s. Persistent cough or cough up blood . . . . . Yes No
t. Immune System disorders (including AIDS, HIV, ARC) . . . . . Yes No
u. Venereal Disease . . . . . Yes No
v. Other _____

8. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma. . . . . Yes No
   a. Do you bruise easily . . . . . Yes No
   b. Have you ever required a blood transfusion . . . . . .Yes No
      If so, explain the circumstances _____
9. Have you ever tested positive for AIDs virus . . . . . .Yes No
10. Do you have a blood disorder such as anemia . . . . . .Yes No
11. Have you had surgery or x-ray treatment for a tumor, growth or other condition . . . . . Yes No
12. Are you taking any of the following
    a. Antibiotics or sulfa drugs . . . . . .Yes No
    b. Anticoagulants (blood thinners) . . . . . .Yes No
    c. Medicine for high blood pressure . . . . . Yes No
    d. Cortisone (steroids) . . . . . .Yes No
    e. Tranquilizers . . . . . Yes No
    f. Antihistamines . . . . . .Yes No
    g. Aspirin . . . . . .Yes No
    h. Insulin, tolbutamide (Orinase) or similar drugs for diabetes . . . . . Yes No
    i. Digitalis or drugs for heart trouble . . . . . .Yes No
    j. Nitroglycerin . . . . . .Yes No
    k. Other medications . . . . . .Yes No
    l. If **YES** to any of the above, state drug name, dosage and frequency:_____
       _____
13. Are you allergic to or have reacted adversely to:
    a. Local anesthetics . . . . . .Yes No
    b. Penicillin or other antibiotics . . . . . .Yes No
    c. Sulfa drugs . . . . . .Yes No
    d. Barbiturates, sedatives or sleeping pills . . . . . .Yes No
    e. Aspirin . . . . . Yes No
    f. Iodine . . . . . .Yes No
    g. Codeine or other narcotics . . . . . Yes No
    h. Latex . . . . . .Yes No
    i. Other. . . . Yes No (If **YES,** please specify:_____)
14. Do you use tobacco products. . . . . Yes No (If so, how much per day and what_____)
15. Do you use any alcohol products . . . . . .Yes No
    If so, how much per day/week/month and what_____
16. Do you use any caffeinated products (coffee, tea, chocolate, etc.) . . . . . Yes No
    If so, how much per day and what_____
17. Do you have any disease, conditions or problem not listed above that you think I should know about . . . . . .Yes No
    If **YES,** please specify:_____
18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation . . . . . Yes No
19. Are you wearing contact lenses . . . . . Yes No
20. Are you experiencing stress or pressure at home or work . . . . . Yes No

WOMEN

21. Are you pregnant . . . . . Yes No
22. Do you have PMS or problems associated with your menstrual period . . . . . .Yes No
23. Are you taking birth control or hormone therapy . . . . . .Yes No

Remarks: To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health or change in my medications, I will inform the dentist at the next appointment.

_____ _____

Signature of Patient or Guardian, if minor **Date** Signature of Dentist Date

Revised 11/16/17

McManus Family Dentistry, LLC
Dan McManus, DMD

Payment Policy

1. In general, payment is due as services are rendered. We accept MasterCard, Visa, and Discover credit cards for your convenience.
2. Your appointment is reserved specifically for you. If you are unable to keep your appointment, we ask that you give us notice to two business days. Failure to give notice will result in a broken appointment fee.
3. We will accept insurance on assignment, but you must satisfy your deductible and pay the percentage of your responsibility as treatment is rendered. (E.g. If your insurance pays 80% of your care, you will be required to pay 20% on each office visit.) Your estimated portion is due at time of service and you will only be billed if there is any additional difference that was not considered.
4. You are required to sign an "Authorization To Pay Dentist/Physician" form and any other assignment documents required by your insurance company on your first visit. If your company requires their particular form to be filled out, you will need to bring that form with you each visit. Without the required form we cannot file for payment and you will be asked to pay for that days visit.
5. Our office does NOT guarantee that your insurance company will pay. If your insurance company fails to pay your claim within 60 days, you will be billed directly for any applicable amounts.
6. Our office will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. However, we will provide whatever support documents and narratives that may be needed to assist you in obtaining your rightful benefits.
7. Since by taking your insurance on assignment we have to wait for payment, this courtesy may be withdrawn if circumstances warrant it.
8. Verification of benefits is required. If we are unable to do so, you will be responsible for payment in full at the time services are rendered.
9. You will be responsible for a 35% "collection fee" if you chose not to pay your balance and are sent to collections.

If you have any questions concerning our office policy, please feel free to ask.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. I authorize the dentist 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 the dentist or dental group 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. I have received a copy of the HIPPA Privacy Act.

_____ _____

Signature (Parent or Guardian, if minor) **Date**

Revised 11/07/2017