Patrick O. Moriarty, DDS. 3514 Clinton Pkwy, Ste G, Lawrence, KS 66047
785-832-2882

Name_____ Preferred Name_____ DOB____/___/___
Last First Middle

Address_____
Number & Street City State Zip Code

SS#_____ Email_____Sex M/F Marital Status: S____ M___W____D____

Home #_____ Mobile #_____ Work #_____

Emergency Contact_____ Phone # _____

Name of Spouse_____ Spouse's Phone #_____

Person responsible for account_____ Relationship_____

Address_____ SS#_____

Home Phone #_____ Work Phone #_____ Mobile #_____

How did you find out about our practice?_____

Primary Dental Insurance Information

Insurance Subscriber_____ DOB_____/_____/_____ SS #_____

Insurance Company_____ Insurance I.D. #_____

Insurance Company Address_____

Employer _____ Plan Name_____ Group #_____

Primary Medical Insurance Information

Insurance Subscriber_____ DOB_____/_____/_____ SS #_____

Insurance Company_____ Insurance I.D. #_____

Insurance Company Address_____

Employer _____ Plan Name_____ Group #_____

Welcome! So that we may provide you with the best possible care
Please complete all sides of this medical/dental history form.
All information is completely confidential.

Dental History

What is the reason for your visit today?_____

Date of Last Dental Visit_____Last Dental Cleaning_____ Last Full Mouth X-rays_____

What was done at your last dental visit?_____

Previous Dentist's Name_____ Telephone #_____

How often do you have dental examinations?_____ Do you have any dental problems now? Yes No

If yes, please describe:_____

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

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Other?	Yes	No
If so where?	Yes	No
Have you noticed any mouth odor or bad taste?	Yes	No
Do you frequently get cold sores, blisters or any other lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Have you been diagnosed with gum/ periodontal disease?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No
If yes, where? _____		
Do you have cracked or broken teeth?	Yes	No
Are you aware of excessively worn teeth?	Yes	No

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects in your teeth?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Have you ever used nitrous "laughing gas"?	Yes	No
Was the use of "laughing gas" helpful to you?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal Treatment?	Yes	No
Relapse of orthodontic straightening?	Yes	No
Your teeth ground or bite adjusted?	Yes	No
A serious injury to the mouth?	Yes	No
If so, please describe_____		
A serious injury to the head?	Yes	No
If so, please describe_____		

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty opening or closing?	Yes	No
Difficulty chewing?	Yes	No
Frequent headaches, neck aches, or shoulder aches ?	Yes	No
Snoring or any other sleep disorders?	Yes	No

Are you happy with your teeth's appearance?	**Yes**	**No**
Would you like to keep your teeth all your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
Have you avoided dental care in the past due to anxiety or fear?	Yes	No

Have you ever taken a prescription prior to a dental appointment? Yes No If so, what?_____

If you could change anything about your dental health or appearance, what would that be (straighter teeth, past dental work, chipped teeth, whiter, teeth, delete space, etc.)?_____

Why?_____

Are you happy with your past dental treatment? Yes No

If not, what caused your dissatisfaction?_____

Is there anything else about having dental treatment that you would like us to know?_____

_____

Medical History

Are you under a physicians care now? Yes No

If yes, for what?_____

Physician Name_____Telephone #_____

Address_____ City_____ State_____ Zip_____

Have you ever been hospitalized or had a major operation? Yes No

If yes:_____

Have you ever had a serious head or neck injury? Yes No If yes:_____

Are you taking any medications, pills, or drugs? Yes No

If yes, please list name and dosage _____

_____

Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phentermine); Pondimen (fenfluramine); and Redux (dexfenfluramine)? Yes No

If yes to the above, did you have a medical exam for heart issues? Yes No

Are you on a special diet? Yes No _____

Do you use tobacco? Yes No

Women: Are you…

☐Pregnant/Trying to get pregnant? ☐Nursing? ☐Taking Oral Contraceptives?

Are you allergic to any of the following? ☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex

☐Sulfa Drugs ☐Local Anesthetics ☐Other?_____

Do you use controlled substances? Yes No If yes_____

Do you have, or have you had, any of the following? Circle Yes or No

AIDS/HIV Positive	Yes	No	Hemophilia	Yes	No
Alzheimer's Disease	Yes	No	Hepatitis A	Yes	No
Anaphylaxis	Yes	No	Hepatitis B / C	Yes	No
Anemia	Yes	No	Herpes	Yes	No
Angina	Yes	No	High Blood Pressure	Yes	No
Arthritis/Gout	Yes	No	High Cholesterol	Yes	No
Artificial Heart Valve	Yes	No	Hives or Rash	Yes	No
Artificial Joint	Yes	No	Hypoglycemia	Yes	No
Asthma	Yes	No	Irregular Heartbeat	Yes	No
Blood Disease	Yes	No	Kidney Problems	Yes	No
Blood Transfusion	Yes	No	Leukemia	Yes	No
Breathing Problems	Yes	No	Liver Disease	Yes	No
Bruise Easily	Yes	No	Low Blood Pressure	Yes	No
Cancer	Yes	No	Lung Disease	Yes	No
Chemotherapy	Yes	No	Mitral Valve Prolapse	Yes	No
Chest Pains	Yes	No	Osteoporosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Pain in Jaw Joints	Yes	No
Congenital Heart Disorder	Yes	No	Parathyroid Disease	Yes	No
Convulsions	Yes	No	Psychiatric Disease	Yes	No

Cortisone Medicine	Yes	No	Radiation Treatments	Yes	No
Diabetes	Yes	No	Recent Weight Loss	Yes	No
Drug Addiction	Yes	No	Renal Dialysis	Yes	No
Easily Winded	Yes	No	Rheumatic Fever	Yes	No
Ephysema	Yes	No	Rheumatism	Yes	No
Epilepsy/Seizures	Yes	No	Scarlet Fever	Yes	No
Excessive Bleeding	Yes	No	Shingles	Yes	No
Excessive Thirst	Yes	No	Sickle Cell Disease	Yes	No
Fainting Spells/Dizziness	Yes	No	Sinus Trouble	Yes	No
Frequent Cough	Yes	No	Spina Bifida	Yes	No
Frequent Diarrhea	Yes	No	Stomach/Intestinal Disease	Yes	No
Frequent Headaches	Yes	No	Stroke	Yes	No
Genital Herpes	Yes	No	Swelling of Limbs	Yes	No
Glaucoma	Yes	No	Thyroid Disease	Yes	No
Hay Fever	Yes	No	Tonsilitis	Yes	No
Heart Attack/Failure	Yes	No	Tuberculosis	Yes	No
Heart Murmur	Yes	No	Tumors or Growths	Yes	No
Heart Pacemaker	Yes	No	Ulcers	Yes	No
Heart Trouble/Disease	Yes	No	Venereal Disease	Yes	No

Have you ever had any serious illness not listed? Yes No If yes_____

Other Comments:_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian

X_____ Date:_____

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Consent to Examination

I understand the above information is necessary to provide me with dental care in a safe and effective manner. I have answered all questions to the best of my knowledge. I will not hold my dentist, or any other member of his/her staff responsible for any action they take or do not take because of errors or omissions that I have made in the completion of this form.
Let my signature below evidence my consent to your dental examination. As a part of that examination, I understand that you and your staff may take x-rays, study models, photographs, and perform other diagnostic procedures which you deem appropriate to make a thorough diagnosis of my dental condition and needs.
I acknowledge to you that I have been given the opportunity to ask questions about the examination, the procedures to be used, and the risks involved-however slight. I believe that I have sufficient information to give you my consent.

_____initial

Insurance and Assignment of Benefits

I understand that my dental insurance is a contract between the insurance carrier and me, and not between the insurance carrier and the doctor and that I am still fully responsible for all dental fees. Any questions regarding your benefit should be directed to your insurance company or human resource person at your place of employment. I understand that any claims that my insurance company has not paid within 45 days become my financial responsibility.
I authorize payment of insurance benefits directly to the doctor, otherwise payable to me. Any payment received by the doctor from my insurance carrier will be credited to my account, or refunded to me if I have paid the dental fee.

_____initial

Financial and Cancellation Policy

Payment is expected in full at the time of service, unless other arrangements have been made. I understand that I am subject to a service charge of 1.5% per month on any balances on my account over 90 days old. Payments are due within 15 days of billing date. Any payments received after 15 days will be assessed a $29 late fee.
A $35.00 charge will be billed to the patient's account for any check returned by the bank for any reason not paid. We will resubmit the check for payment to the bank. Delinquent accounts may be sent to a collection agency or referred for legal action. If your account is sent to a collection agency, the collection fees we incur will be added to your account. I have read and understand the cancellation policy and the financial policy of Dr. Moriarty and agree to all the terms described in it.
We reserve the right to charge a nominal fee of $58 for missed appointments or appointments cancelled with less than 48 hours or your appointment time.

_____initial

Notice of Privacy Practices

I understand that under the Health Insurance Portability and Accountability (HIPAA) Act of 1996, I have certain privacy rights regarding my protected health information and uses for such information. I understand I may request in writing restrictions on how my information is used or disclosed to carry out treatment, payment or health care operations. Enhance Dental Care of Lawrence may not agree to such requests, but if agreed to, then Enhance Dental Care of Lawrence is bound by said request.

_____Initial

I authorize the release of a full report of examination findings, diagnosis, treatment program etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims.

Signature_____Date_____