

J. Brian Murphy, D.D.S., P.A.
Implant & Oral Surgeon

TODAY'S DATE: ____ / ____ / ____

NAME: (Dr / Mr / Miss / Mrs / Ms) _____
(Please Circle) (First) (M.I.) (Last)

NICKNAME/PREFERRED NAME: _____

ADDRESS: _____
(Street) (City/State) (Zip)

ALTERNATE ADDRESS: _____
(Street) (City/State) (Zip)

HOME PHONE: (_____) _____ WORK PHONE:(_____) _____ EXT: _____

ALTERNATE PHONE: (_____) _____ FAX: (_____) _____

DATE OF BIRTH: _____ AGE: _____ MALE / FEMALE SOC. SEC. # _____
(Month Day Year) (Please Circle)

MARITAL STATUS: SINGLE MARRIED DIVORCED SEPARATED WIDOWED

OCCUPATION: _____

EMPLOYER NAME & ADDRESS: _____

REFERRED BY: _____ GENERAL DENTIST: _____

PHYSICIAN NAME & CITY _____ PHONE (_____) _____

Are you under the care of an additional physician for any reason? (Cardiologist/Hematologist, etc.) Yes No

If yes, please explain: _____

When was your last physical examination? _____ Was anything unusual or abnormal found?..... Yes No

If yes, please explain: _____

Have you ever had any operations, hospitalizations or serious illness?..... Yes No

If yes, please explain: _____

Have you been a patient in our office? _____ Has any member of your family been a patient in our office? _____

If yes, name _____

What is the name and location of your pharmacy ? _____

CONTINUED ON BACK

General Health Questionnaire

Is there a past history of alcohol, chemical dependency, psychiatric treatment, nervous or emotional disorder that may affect the care we provide you?..... Yes No

Do you have a cold or cough at this time?....Yes No How much do you weigh?_____

Do you drink alcoholic beverages?.....Yes No If yes, how much?_____

Do you smoke or chew tobacco?.....Yes No If yes, how much?_____

Do you have HIV or AIDS?.....Yes No

Have you had General Anesthesia before? Yes No Do you wear contact lenses?.....Yes No

Have you or a member of your family ever had difficulty with, or a bad reaction to General Anesthesia? Yes No

If yes, please explain:_____

FEMALE PATIENT: Are you, or could you be pregnant? Yes No
Are you taking birth control pills? Yes No
Are you nursing? Yes No

FOR YOUR INFORMATION:
Antibiotics may interfere with the effectiveness of oral contraceptives

The disclosure of medical information is for your general welfare, whether you are here for diagnostic consultation, a simple extraction, or a major oral surgical procedure. Your general health may have a significant affect on your current condition and on the outcome of any proposed treatment. For the sake of your overall health and safety, please answer all questions.

I CERTIFY THAT THE MEDICAL HISTORY I HAVE GIVEN ABOVE IS CORRECT:

X _____
Patient's Signature Date Parent/Guardian Signature (if minor)

DOCTOR'S REVIEW:

▶ _____
Doctor's Signature Date

ASSISTANT'S REVIEW

▶ _____
Assistant's Signature

FOR OFFICE USE ONLY

I have read my health history dated ____ / ____ / ____ and confirm that it adequately states past and present conditions.

List exceptions or changes

Are you taking any new medications? Yes No If yes, please list:_____

Date Patient's Signature Doctor's Initials

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GENERAL HEALTH QUESTIONNAIRE

▶ **PATIENT NAME:** _____ **Date of Birth:** _____ **Age:** _____

Do you have or have you ever had:	Yes	No
Rheumatic fever		
Congenital heart disease		
Mitral valve prolapse		
Heart murmur		
Heart surgery/Blood vessels		
Heart valve replacement		
Prosthetic (artificial) joints		
High Cholesterol		
Angina (chest pain)		
Irregular heart beat		
Coronary artery disease		
Heart disease/Heart attack		
Cardiac pacemaker		
Swelling of the ankles		
High or low blood pressure		
Stroke/TIA		
Bleeding problems		
Anemia		
Seizures/Epilepsy		
Dizziness/Fainting		
Any Other Disease or Condition		

Do you have or have you ever had:	Yes	No
Lung Conditions –Specify		
Tuberculosis		
Sinus problems		
Thyroid disease		
Glaucoma		
Kidney disease		
Liver disease/Hepatitis		
Diabetes		
Neurological Conditions - Specify		
Gastrointestinal problems		
Arthritis / Joint pain / back problems		
Cancer		
Radiation/chemotherapy treatments		
History of prescription diet pills		
TMJ symptoms/treatment		
Prostate problems		
Osteoporosis		
Specify:		

ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

	YES	NO
Local anesthetics		
Penicillin / Amoxicillin		
Sulfa drugs		
Other antibiotics		
Iodine / Betadine		
Neosporin		

	YES	NO
Sedatives, barbiturates		
Codeine		
Other narcotics		
Aspirin or Ibuprofen		
Latex		
Adhesive Tape		

Please list additional allergies _____

ARE YOU TAKING ANY OF THE FOLLOWING MEDICINES?

	YES	NO
Any type of Blood thinners		
Aspirin or Ibuprofen		
Coumadin		
Vitamin E		
Glucosamine		

	YES	NO
Diuretics/Water pills		
Insulin or oral anti-diabetic drugs		
Blood pressure medicine		
Prednisone / steroids		
Medications for osteoporosis		

Please list all current medications: _____

Implant & Oral Surgeon

FINANCIAL POLICY

As a courtesy and added benefits to our patients with insurance, we are more than happy to file your insurance for you. However, we do require you to pay the estimated percentage your insurance does not cover plus any deductible at the time of your appointment.

IF YOU HAVE INSURANCE PLEASE READ THIS IMPORTANT INFORMATION:

We will call your insurance company to verify your benefits and will review your treatment plan with you. Most insurance companies pay a percentage of what they consider to be usual and customary fee. Please understand that your insurance policy is not a "pay all", it is only assistance for you. You are ultimately responsible for all cost of your Surgical/Dental treatment. Your insurance company has a responsibility to you, NOT us; therefore it is your responsibility to pursue any payment issues with them. It is not our policy to contact your insurance carrier to establish why they have not paid or why they paid less than originally indicated. **As a Dental Office we do not file with Medical.** Please contact the insurance company immediately if there are any concerns. We will extend this credit for 60 days. After that our office requires you to pay the balance in full.

I _____, understand that I am ultimately responsible for all of the dental treatment.

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT (IF OTHER THAN SELF)

NAME _____ RELATION TO PATIENT _____ DOB _____

ADDRESS _____

EMPLOYER _____

(NAME)

(ADDRESS/CITY/STATE)

HOME PHONE (____) _____ WORK PHONE (____) _____ SOC.SEC# _____

****I have read and understand the financial policy** _____

(PATIENT/GUARANTOR)

DATE

Name of Insurance Party _____ D.O.B. _____

S.S.# of Insured _____ Name Of Insurance Co. _____

Address _____ City/State, Zip _____

Insurance Co. Phone _____ Group No. _____

Insured's Employer _____

I hereby authorize release of any medical or other information necessary to process this claim.

I authorize payment of benefits otherwise payable to me directly to J. Brain Murphy D.D.S., P.A.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

INSURED SIGNATURE