



Mike Malone, D.D.S., F.A.G.D.

Accredited by The American Academy of Cosmetic Dentistry
Fellow of the Academy of General Dentistry

Patient Information

Date _____

Name _____ Home Phone _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Social Security #: _____ E-mail _____

Check Appropriate Box Minor Single Married Divorced Widowed Separated

Patient's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Who May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Social Security # _____ Birthdate _____

Employer _____ Work Phone _____

Occupation _____

Is This Person Currently a Patient in our Office? Yes No

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Phone _____

Ins. Co. Address _____ City _____ State _____ Zip _____

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Insurance Authorization Signature _____ Date _____

Payment is due in full at time of treatment.

Please indicate preferred method of payment:

Cash or Check at time of appointment

Visa, Discover, or Mastercard

Patient Medical Record

Patient Name _____ Date _____
 Name and address of physician (Medical Doctor): Name _____ City _____
 Have you been under a physician's care during the past 2 years? _____ For _____
 Have you ever had major surgery? _____ If yes, date and procedure _____
 Do you smoke or use tobacco in any form? _____ If so, what type and how much? _____
 Are you now taking or have you taken any prescription drugs during the past year? _____ Please list _____

Women:

Are you pregnant or think you may be pregnant? yes no Nursing? yes no Taking birth control pills? yes no

Please check any of the following drugs you have ever taken:

Penicillin Blood Thinners Insulin Thyroid Nitroglycerin Other _____
 Cortisone Tranquilizers Digitalis Dilantin Phen-Fen/Redux

Please check any of the following that you are allergic to or have had a bad reaction to:

Local Anesthetics Codeine Sulfa Drugs Iodine Other _____
 Aspirin Penicillin Barbiturates Latex

Place a mark on "yes" or "no" to indicate if you have had any of the following:

	yes	no		yes	no
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism/Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
If yes, with or without regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Heart Failure/ Attack	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Radiation/Cobalt Treatment	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy (Cancer, Leukemia)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesions	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Immune Deficiency Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B, C	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints (Hip, Knee)	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Cosmetic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>
Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores/Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever/Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Drug Dependency	<input type="checkbox"/>	<input type="checkbox"/>
Allergies or Hives	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>

Have you had any disease, condition, or medical situation not previously listed? _____

Medical Release: I understand that the information contained in my case record is confidential. However, I give my consent for Mike Malone, D.D.S. & Associates to release to my physician any information which may be helpful in his/her understanding of my present health situation.

Patient Signature _____ Date _____



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DENTAL HEALTH

When was your last dental visit? _____ How often did you see the dentist? _____

Are you having any dental problems that require immediate attention? _____

Do any of the following cause tooth discomfort? Hot _____ Cold _____ Sweets _____ Chewing _____

How often do you brush your teeth? _____ Floss? _____ Medicated rinse? _____

Do your gums bleed while cleaning? _____ Do your gums ever feel tender or swollen? _____

Have you had periodontal gum treatment? _____ When? _____

Do you clench or grind your teeth? _____ Do your jaws ever feel tired or ache? _____ Click or pop? _____

Can you chew on both sides of your mouth? _____ Comfortable? _____

Do you have frequent headaches? _____ Earaches? _____ Neck or shoulder pain? _____

Have you had orthodontic treatment (braces)? _____ When? _____

Do you usually have many cavities? _____ Do you lose fillings or break fillings? _____

Do you have any loose teeth? _____ Cracked or broken teeth? _____

Do you have any noticeable wear on your teeth? _____ Food traps? _____

Do you have any missing teeth? _____ Have they been replaced? _____

If so, how? Fixed bridge _____ Removable partial _____ Full denture _____ Dental implant _____

Are you comfortable with the replacement? _____ Please describe _____

Have you ever had an unpleasant dental experience? _____

CIRCLE CORRECT ANSWER(S):

- | | | | |
|----------------|--|--|---|
| 1. My mouth is | A) very comfortable | 5. I have | A) always done the best that was recommended for my dental health |
| | B) moderately comfortable | | B) have not done what dentists have recommended for my mouth |
| | C) uncomfortable | | C) rarely go, and don't care much about having any dental work completed. |
| 2. I | A) think the appearance of my mouth is excellent | 6. I have | A) put dentistry for myself and my family high on my priority list |
| | B) am satisfied with the appearance of my mouth | | B) put dentistry for myself and my family low on my priority list |
| | C) am dissatisfied with the appearance of my mouth | | C) it's on my list but hard to find |
| 3. I | A) will do anything to keep my natural teeth | 7. I think my present state of dental health is: | A) Excellent |
| | B) want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them | | B) Good |
| | | | C) Poor |
| 4. I | A) have set goals for my oral health with a previous dentist | 8. I would like a mouth with: | A) Excellent health |
| | B) have never set goals concerning my oral health | | B) Good health |
| | C) want to set goals concerning my dental health | | C) Poor health |

What are some questions about dentistry and oral health that you have never had adequately answered?

(over)

General Dentistry • Cosmetic Dentistry • Restorative Dentistry • Implant Dentistry

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SMILE EVALUATION

Hold a full face mirror 12" - 14" from your face. Smile to show your teeth; take the time to observe your teeth carefully. Then answer the following questions. (It is helpful to have a friend ask you the questions).

			Date
<i>Last</i>	<i>First</i>	<i>Middle</i>	
1.	Do you like the overall appearance of your teeth, your smile? If NO, please describe _____ _____		<input type="checkbox"/> YES <input type="checkbox"/> NO
2.	Do you consider that your teeth are in good alignment (straight)? If NO, please describe _____		<input type="checkbox"/> YES <input type="checkbox"/> NO
3.	Do you have spaces between your teeth that you don't like? If YES, please describe _____		<input type="checkbox"/> YES <input type="checkbox"/> NO
4.	Do you like the color of your teeth? If NO, please describe _____		<input type="checkbox"/> YES <input type="checkbox"/> NO
5.	Do your teeth have unattractive stains? <input type="checkbox"/> Tobacco stains <input type="checkbox"/> Coffee/tea stains <input type="checkbox"/> Discolored fillings <input type="checkbox"/> Tetracycline stains <input type="checkbox"/> Silver filling stains <input type="checkbox"/> Other _____		<input type="checkbox"/> YES <input type="checkbox"/> NO
6.	Do you like the shape of your teeth? If NO, please describe _____		<input type="checkbox"/> YES <input type="checkbox"/> NO
7.	Do you think that your teeth are attractive? <input type="checkbox"/> chipped <input type="checkbox"/> overlapping <input type="checkbox"/> protruding <input type="checkbox"/> excessively worn <input type="checkbox"/> hidden <input type="checkbox"/> artificial looking		<input type="checkbox"/> YES <input type="checkbox"/> NO
8.	Do you like the way that your upper and lower teeth come together? If NO, please describe _____		<input type="checkbox"/> YES <input type="checkbox"/> NO
9.	Do you consider that your existing fillings or dental work is unattractive? If YES, please describe _____ _____		<input type="checkbox"/> YES <input type="checkbox"/> NO
10.	Do you think that your gums are unattractive? <input type="checkbox"/> swollen <input type="checkbox"/> excessively receded <input type="checkbox"/> reddened <input type="checkbox"/> crowns are ill-fitting <input type="checkbox"/> bleed easily <input type="checkbox"/> difficult to clean between teeth		<input type="checkbox"/> YES <input type="checkbox"/> NO
11.	What would you like to change the most in the appearance of your teeth, your smile? _____ _____ _____ _____		