



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 _____