Mike Malone, D.D.S. & Assoc.

A Commitment to Excellence

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

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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	❑	❑	Rheumatism/Arthritis	❑	❑
If yes, with or without regurgitation	❑	❑	Cortisone Medicine	❑	❑
Heart Failure/ Attack	❑	❑	Thyroid Disease	❑	❑
Heart Disease	❑	❑	Cancer	❑	❑
Angina Pectoris	❑	❑	Radiation/Cobalt Treatment	❑	❑
High Blood Pressure	❑	❑	Chemotherapy (Cancer, Leukemia)	❑	❑
Heart Murmur	❑	❑	Glaucoma	❑	❑
Rheumatic Fever	❑	❑	Polio	❑	❑
Congenital Heart Lesions	❑	❑	Sickle Cell Anemia	❑	❑
Artificial Heart Valve	❑	❑	Lupus	❑	❑
Heart Pacemaker	❑	❑	Immune Deficiency Disease	❑	❑
Heart Surgery	❑	❑	Hepatitis A, B, C	❑	❑
Artificial Joints (Hip, Knee)	❑	❑	Liver Disease	❑	❑
Anemia	❑	❑	Yellow Jaundice	❑	❑
Stroke	❑	❑	Blood Transfusion	❑	❑
Kidney Trouble	❑	❑	Hemophilia	❑	❑
Ulcers	❑	❑	Prolonged Bleeding	❑	❑
Cosmetic Surgery	❑	❑	Bruise Easily	❑	❑
Pain in Jaw Joints	❑	❑	Sexually Transmitted Disease	❑	❑
Organ Transplant	❑	❑	Cold Sores/Fever Blisters	❑	❑
Emphysema	❑	❑	Herpes	❑	❑
Cough	❑	❑	Epilepsy	❑	❑
Tuberculosis (TB)	❑	❑	Fainting or Dizzy Spells	❑	❑
Asthma	❑	❑	Nervousness	❑	❑
Hay Fever/Sinus Trouble	❑	❑	Drug Dependency	❑	❑
Allergies or Hives	❑	❑	Psychiatric Treatment	❑	❑
Diabetes	❑	❑	Hypoglycemia	❑	❑

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

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

_____
_____
_____
_____

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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 _____

Last *First* *Middle*

1. Do you like the overall appearance of your teeth, your smile? ❑ YES ❑ NO
   If NO, please describe _____
   _____

2. Do you consider that your teeth are in good alignment (straight)? ❑ YES ❑ NO
   If NO, please describe _____

3. Do you have spaces between your teeth that you don't like? ❑ YES ❑ NO
   If YES, please describe _____

4. Do you like the color of your teeth? ❑ YES ❑ NO
   If NO, please describe _____

5. Do your teeth have unattractive stains? ❑ YES ❑ NO
   - ❑ Tobacco stains
   - ❑ Discolored fillings
   - ❑ Silver filling stains
   - ❑ Coffee/tea stains
   - ❑ Tetracycline stains
   - ❑ Other _____

6. Do you like the shape of your teeth? ❑ YES ❑ NO
   If NO, please describe _____

7. Do you think that your teeth are attractive? ❑ YES ❑ NO
   - ❑ chipped
   - ❑ protruding
   - ❑ hidden
   - ❑ overlapping
   - ❑ excessively worn
   - ❑ artificial looking

8. Do you like the way that your upper and lower teeth come together? ❑ YES ❑ NO
   If NO, please describe _____

9. Do you consider that your existing fillings or dental work is unattractive? ❑ YES ❑ NO
   If YES, please describe _____
   _____

10. Do you think that your gums are unattractive? ❑ YES ❑ NO
    - ❑ swollen
    - ❑ reddened
    - ❑ bleed easily
    - ❑ excessively receded
    - ❑ crowns are ill-fitting
    - ❑ difficult to clean between teeth

11. What would you like to change the most in the appearance of your teeth, your smile?
    _____
    _____
    _____
    _____
    _____

(Over)