MALLOY & DEVINE
SIGNATURE DENTAL

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Gender: _____

Address: _____

City: _____ State: _____ ZIP _____

Email: _____ Phone: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Emergency Contact: _____ Phone: _____

Previous Dentist: _____ Dental Office: _____

How did you hear about us?

☐ I live/work in area ☐ I was referred by _____

☐ Social media ☐ Other _____

DENTAL INSURANCE INFORMATION

☐ No Dental Insurance

☐ Primary Dental Insurance

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ☐ Self ☐ Parent ☐ Spouse ☐ Child ☐ Other

HIPAA ACKNOWLEDGEMENT

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will be not effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on the authorization I have signed. I understand that my health care and the payment for my health care will not be effected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentially.

Patient/ Guardian Name (print) _____ **Date** _____

Patient/ Guardian Name (sign) _____ **Date** _____

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RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information of my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information provided.

Patient/ Guardian Name (print) _____ **Date** _____

Patient/ Guardian Name (sign) _____ **Date** _____

PHOTO AND VIDEO CONSENT

I hereby authorize Dr. Malloy, DMD, Dr. Devine, DMD, and whomever he may designate his assistants to use photographs and videos taken during my treatment for patient education, presentation, and/or publication purposes.

Patient/ Guardian Name (print) _____ **Date** _____

Patient/ Guardian Name (sign) _____ **Date** _____

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PATIENT'S DENTAL APPROACH

Our philosophy is to help each patient achieve the highest level of dental health that is appropriate for them, recognizing that not all patients have the same dental needs or desires.

With that in mind, we would like you to identify how you would like to be seen in our office by checking which of the three levels seem appropriate to you at this time. Please understand that it is not uncommon for patients to chose a different path after they have experienced our office, but this helps as a starting point.

- [ ] LEVEL 1 REACTIVE CARE: Patients at this level are generally interested in solving only the most urgent problems They typically want the treatment performed to be the quickest and least expensive repair possible..

- [ ] LEVEL 2 PROACTIVE CARE: Patients at this level generally request a thorough examination and want to be actively involved in the correction of present dental problems and the prevention of future dental problems. They typically prefer repair of current problems and prevent foreseeable future dental problems.

- [ ] LEVEL 3 REGENERATIVE CARE: Patients at this level have a very high interest in their dental health and appearance. They request a comprehensive dental evaluation and a thorough report of the consequences of any current and potential problems noted in the examination. Ultimately, they want to be involved in creating a long term plan for their dental health which includes choosing the longest lasting solutions to current and potential dental problems.

We hope these different levels make sense to you, and as we stated before, it is not uncommon for patients to change their level of care after beginning treatment with us. We look forward to seeing you and helping you achieve the level of dental care most appropriate for you.

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MEDICAL HISTORY

Patient Name: _____ **Date:** _____

Cardiac (Heart) Health

_____ Pacemaker
_____ Implanted Defibrillator
_____ Artificial Heart Valve
_____ Previous Infective Endocarditis
_____ Congenital Heart Disease
_____ Arteriosclerosis
_____ Coronary Artery Disease
_____ Congestive Heart Failure
_____ Damaged Heart Valve
_____ Heart Attack
_____ Heart Murmur/Rhythm Disorder
_____ Rheumatic Heart Disease
_____ High Cholesterol

Autoimmune Diseases

_____ AIDS or HIV infection
_____ Lupus
_____ Sjogren's

Respiratory (Breathing) Health

_____ Asthma (COPD)
_____ Bronchitis
_____ Emphysema
_____ Tuberculosis

Circulatory (Blood) Health

_____ Anemia
_____ Blood Transfusion
If yes, date _____
_____ Hemophilia
_____ High Blood Pressure
_____ Low Blood Pressure

Eye

_____ Glaucoma

Brain/Mental Health

_____ Dementia
_____ Anxiety and/or Depression
_____ Stroke
_____ Mental Health Disorders
_____ Neurological Disorders
_____ Post-traumatic Stress Disorder
_____ Traumatic Brain Injury
_____ Concussion
_____ Epilepsy

Digestive Health

_____ Gastrointestinal Disease
_____ GE Reflux/GERD
_____ Stomach Ulcers

Cancer

Type _____
Date of Diagnosis _____
Chemotherapy _____
Radiation Treatment _____

Other

_____ Arthritis
_____ Diabetes Type 1 or Type 2
_____ Eating Disorder
_____ Hepatitis, jaundice, liver disease
_____ Immune Deficiency
_____ Kidney Problems
_____ Osteoporosis
☐ Injections ☐ IV ☐ Pill
_____ Rheumatoid Arthritis
_____ Sexually Transmitted Infection
_____ Hypothyroidism
_____ Hyperthyroidism

MEDICAL CONDITIONS NOT LISTED:

_____

_____

ALLERGIES

_____ Aspirin
_____ Barbiturates, sedatives or sleeping pills
_____ Codeine or other narcotics
_____ Hay fever/seasonal allergies
_____ Iodine
_____ Latex (rubber)
_____ Local Anesthetics
_____ Metals
_____ Penicillin or Amoxicillin
_____ Other antibiotics
_____ Sulfa drugs
_____ Other _____

MEDICATION LIST (please include all prescription medications):

_____

_____

_____

_____

_____

_____

MEDICAL AND SURGICAL HISTORY:

Please use an "x" to mark your answers to the following questions

Current physician's name and phone number _____

Has a physician or previous dentist recommend you take antibiotics before having dental work done? ☐ **Y** ☐ **N**

Have you had a serious illness, operation or been hospitalized within the last **2 years**? ☐ **Y** ☐ **N**

Have you had any type of joint replacement surgery within the last **2 years?** ☐ **Y** ☐ **N**

If yes, date _____

Have you had a heart valve replacement or heart surgery in the last **2 years?** ☐ **Y** ☐ **N**

Have you had a stroke or heart attack within the last **6 months?** ☐ **Y** ☐ **N**

If yes, date _____

Have you had an organ or bone marrow/stem cell transplant within the last **6 months?** ☐ **Y** ☐ **N**

Patient /Guardian (print) _____ **Date** _____

Patient/Guardian (sign) _____ **Date** _____