McCarthy Dentistry

405 Second Street • Marietta, Ohio •740-373-6464
www.mytotaldentistry.com

How did you hear about us?

☐ Big Book ☐ ATT Yellowpages ☐ Verizon Yellowpages ☐ Internet Friend _____ Family _____ Other _____

Name: _____
Last First MI Title

Preferred Name: _____ ○ Male ○ Female

Address: _____ City: _____ State: _____ ZIP: _____

SSN: _____ DOB: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____ Preferred Method of Contact: _____

Employer: _____ Occupation: _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated ○ Domestic Partner

Insurance – Primary

Subscriber Name: _____ Relationship to Patient: _____

Subscriber SSN/ID: _____ Subscriber DOB: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Insurance – Secondary

Subscriber Name: _____ Relationship to Patient: _____

Subscriber SSN/ID: _____ Subscriber DOB: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage and assign directly to Today's Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Parent/Guardian Signature: _____

See Reverse Side for Additional Information →

Dental History

Reason for today's visit: _____

_____

Former Dentist: _____

City/State: _____

Date of last dental visit: _____

Date of last dental X-rays: _____

Place a mark on "☐" to indicate if you have had any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette, pipe, or cigar smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between teeth
- ☐ Foreign objects
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain or tiredness
- ☐ Lip or cheek biting
- ☐ Mouth breathing
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____

How often do you brush? _____

Medical History

Do you have a personal physician? ○ Yes ○ No

Physician's Name: _____ Physician's Phone: _____

Date of last visit: _____

Your current physical health is: ○ Good ○ Fair ○ Poor

Are you currently under the care of a physician? ○ Yes ○ No

Please explain: _____

Do you use tobacco in any form? ○ Yes ○ No

Are you taking any medications? ○ Yes ○ No

Please list each one: _____

Conditions

- ☐ Abnormal Bleeding
- ☐ Alcohol Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Facial Surgery
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Frequent Headaches

Conditions

- ☐ Glaucoma
- ☐ HIV + AIDS
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Shingles

Conditions

- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Tetracycline

If Female, Please Answer

Are you taking Birth Control pills? ○ Yes ○ No

Are you pregnant? ○ Yes ○ No

If so, # of weeks: _____

Are you nursing? ○ Yes ○ No

Nearest relative not living with you:

Name: _____ Relationship: _____

Address: _____ Phone: _____

I understand that the information that I have given today is a correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

Submit by email to mytotaldentistry@gmail.com

requires email address

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