Thomas F. Mahar, D.D.S.

Patient History

Name

Date:

Patient: _____ Age:_____ Birth date: _____ ❑ Male ❑ Female

Email: _____

Address: _____ City:_____ State:_____ Zip:_____

Social Security #: _____ Home Phone #:_____

Employer: _____ Work Phone #:_____

Employer's Address: _____

Spouse: _____ Birth date:_____

Address (if different):_____ Social Security #: _____

Employer & Address:_____ Phone: _____

Person responsible for Dental Investment:_____ Relationship to patient: _____

Address (if different):_____

Social Security # of Insured Person: _____ Birth date:_____

Employer & Address:_____ Phone: _____

Name of Insurance Co. _____ Address: _____

Name of Secondary Insurance Co. _____ Address: _____

In case of emergency who should we contact?_____

Name & phone number of the nearest relative? _____

Who referred you to our office: _____

Please check those that apply to you only.

Medical History

Your medical doctor's name:_____ Location:_____ Phone: _____

How would you describe your present health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Please check yes or no to the following questions:	Yes	No
Have you been a patient in a hospital during the past two years?	❑	❑
If so, purpose of stay? _____		
Do you take any kind of medicines or blood thinners?	❑	❑
If yes, please explain: _____		
Are you allergic to penicillin or any other medicines or drugs?	❑	❑
If yes:_____		
Do you have any food allergies? _____		
Are you aware of needing any PreMedication or antibiotic prior to dental treatment? _____		

____High Blood Pressure	____Diabetes	____Hiatal Hernia	____Mitral Valve Prolapse
____Low Blood Pressure	____Kidney Problems	____Stroke	____Sinus Problems
____Heart Problems	____Asthma	____Cancer History	____TMJ Problems
____Rheumatic Fever	____Emphysema	____Steroid Use History	____Smoker
____Heart Murmur	____Bleeding Disorder	____Arthritis	____HIV Positive
____Hepatitis	____Seizure Disorder	____Prosthesis Joint	____Thyroid Problems

Women: Taking Birth Control pills?_____ Are you Pregnant?_____

What is your present problem?

_____

When was your last dental appointment?

_____

_____

Are your teeth sensitive to:	YES	NO	
Heat, Cold, Sweets, Biting Pressure?	❑	❑	_____
Do your gums bleed when brushing?	❑	❑	_____
Have you noticed any gum swelling around any teeth?	❑	❑	_____
Have you ever considered brightening your smile?	❑	❑	_____
If you could have the perfect smile, how would you describe it?	❑	❑	_____
Is there anything that would prevent you from receiving the treatment you would like?	❑	❑	_____
Do you grind or clench your teeth?	❑	❑	_____
Have you been diagnosed with sleep apnea?	❑	❑	_____
Do you snore?	❑	❑	_____
Do you have an unpleasant taste or odor in your mouth?	❑	❑	_____
Have you ever had any teeth removed?	❑	❑	_____

How long have these teeth been missing? _____

Do you have any dentures? ❑ Partials ❑ Crowns ❑ Implants

How old are they? _____

Date _____

Name _____

I understand and agree that, (regardless of my insurance status). I am ultimately responsible for the balance of my account for any professional services rendered. In the event this account becomes past due and is turned over for collection, I agree to pay a $50 filing fee, attorney fees, collection fees, and court cost, if necessary. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Patient or Guardian Signature_____ Date_____

(Payment Plans are available if needed for extensive treatments.)