Dr. Maricela Murillo, D.D.S

General & Family Dentistry

Treating the Person Behind the Smile

PLEASE COMPLETE ALL INFORMATION THAT APPLIES TO YOU · THANK YOU!

PATIENT LAST NAME: _____ **FIRST:** _____ **INITIAL:** ____

How do you wish to be addressed? _____ **DOB** _____

(☐Single ☐Married ☐Divorced) (☐Male ☐Female) Full Time Student? ☐Yes ☐No School _____

Address _____ City _____ State _____ ZIP _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____ Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

Is patient covered by another dental insurance? ☐Yes ☐No Insurance Co. _____

How did you hear about our practice? Whom may we thank for your referral? _____

HUSBAND, FATHER OR RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

LAST NAME: _____ FIRST: _____ INITIAL: __ DOB _____

Address _____ City _____ State _____ ZIP _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____ Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

WIFE, MOTHER OR RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

LAST NAME: _____ FIRST: _____ INITIAL: __ DOB _____

Address _____ City _____ State _____ ZIP _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____ Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

NEAREST RELATIVE

LAST NAME: _____ FIRST: _____ INITIAL: __

Address _____ City _____ State _____ ZIP _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the 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 the release of any information concerning 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 or my dental benefits may pay less than the actual bill for services. I understand 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 payments of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

Signature _____ Date _____

PATIENT REGISTRATION

PLEASE COMPLETE ALL INFORMATION - THANK YOU!

PATIENT LAST NAME: _____ **FIRST NAME:** _____

Reason for today's visit? _____ Date of last dental visit _____

Former dentist _____ Date of last dental x-rays _____

Please check if you have/had:	Yes	No		Yes	No		Yes	No
Bad breath	☐	☐	Head, neck, jaw pain, or aches	☐	☐	Have you ever had an allergic reaction to Novocaine,		
Blisters on lips or mouth	☐	☐	Lip or cheek biting	☐	☐	local, or general anesthetics? ☐ Yes ☐ No		
Burning sensation on tongue	☐	☐	Loose teeth or broken fillings	☐	☐	If yes, please explain:		
Chew on one side of the mouth	☐	☐	Mouth breathing	☐	☐			
Cigarette, pipe, or cigar	☐	☐	Orthodontic treatment	☐	☐			
Smokeless tobacco	☐	☐	Do you snore	☐	☐			
Dry mouth	☐	☐	Periodontal treatment	☐	☐			
Food collection between teeth	☐	☐	Sensitivity to pressure, cold,	☐	☐	Do you require antibiotic premedication prior to		
Clench or grind teeth	☐	☐	heat or sweets			dental care? ☐ Yes ☐ No If yes, please explain why		
Growths or sore spots in mouth	☐	☐	How often do you floss? _____					
Gums swollen, tender, bleeding	☐	☐	How often do you brush? _____					

Physician's name _____ Date of last visit _____

Physician's phone # _____

Have you had any serious illnesses or operations ☐ Yes ☐ No If yes, please describe _____

Have you ever had a blood tranfusion ☐ Yes ☐ No If yes, list approximate date(s) _____

(Women) Are you pregnant? ☐ Yes ☐ No Due date _____ Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Please check if you have/had:	Yes	No		Yes	No		Yes	No		Yes	No
Allergies, hay fever, sinusitis	☐	☐	Diabetes	☐	☐	Radiation treatments	☐	☐	Swelling of feet or, ankles	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Respiratory disease	☐	☐			
Arthritis, Rheumatism	☐	☐	Epilepsy	☐	☐	Rheumatic fever	☐	☐	Thyroid problems	☐	☐
Artificial heart valves	☐	☐	Fainting	☐	☐	Shortness of breath	☐	☐	Tonsilitis	☐	☐
Artificial joints	☐	☐	Glaucoma	☐	☐	Sinus trouble	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Headaches	☐	☐	Sickle cell anemia	☐	☐	Tumor or growth on head/neck	☐	☐
Required Hospitalization	☐	☐	Heart murmur	☐	☐	Sleep apnea	☐	☐			
Have you used steroids	☐	☐	Heart problems	☐	☐	Slow healing wounds	☐	☐	Ulcer	☐	☐
Date of last episode _____	☐	☐	Hepatitis type _____	☐	☐	Stroke	☐	☐	Cold sores	☐	☐
Bleeding abnormally with operations or surgery	☐	☐	Herpes	☐	☐				Weight loss unexplained	☐	☐
			High blood pressure	☐	☐				Do you consume alcoholic beverages?	☐	☐
Blood disease/clotting disorders	☐	☐	Any immune deficiency	☐	☐				Are you currently under the care of a Physician?	☐	☐
Cancer	☐	☐	Jaundice	☐	☐				Are you allergic/sensitive to Latex?	☐	☐
Chemical dependency	☐	☐	Kidney disease	☐	☐				**Allergic** to Penicillin, Aspirin, or other drugs?	☐	☐
Chemotherapy	☐	☐	Low blood pressure	☐	☐				If yes, please specify		
Circulatory problems	☐	☐	Mitral valve prolapse	☐	☐						
Cortisone treatments	☐	☐	Osteoporosis	☐	☐				List any medications that you are taking		
Cough, persistent or bloody	☐	☐	Pacemaker	☐	☐						

I have read and answered the above questions to the best of my knowledge

Patient/Guardian Signature _____ Date _____

Reviewed By _____ Date _____