



# Patrick A. Murray, D.D.S., P.C.

## MEDICAL HISTORY

Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? \_\_\_\_\_  
Yes No Are you allergic to any medication? \_\_\_\_\_  
Yes No Do you have a history of a major illness? \_\_\_\_\_  
Yes No Have you had any operations? \_\_\_\_\_  
Yes No Have you ever been involved in a serious accident? \_\_\_\_\_  
Yes No Have you ever smoked or chewed tobacco? \_\_\_\_\_  
Yes No Have seen a physician in the last 12 months? Why? \_\_\_\_\_  
Female Patients only:  
Yes No Are you pregnant? \_\_\_\_\_

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? \_\_\_\_\_

## DENTAL HISTORY

Reason for your visit \_\_\_\_\_ Date of last visit \_\_\_\_\_

What concerns you most about your teeth? \_\_\_\_\_

Yes No Are you presently in any dental pain? \_\_\_\_\_  
Yes No Have you ever experienced any unfavorable reaction to dentistry? \_\_\_\_\_  
Yes No Have your wisdom teeth been removed? \_\_\_\_\_  
Yes No Have you ever lost or chipped any teeth? \_\_\_\_\_  
Yes No Have there been any injuries to face, mouth, or teeth? \_\_\_\_\_  
Yes No Is any part of your mouth sensitive to temperature? Where? \_\_\_\_\_  
Yes No Is any part of your mouth sensitive to pressure? Where? \_\_\_\_\_  
Yes No Do your gums bleed when you brush? \_\_\_\_\_  
Yes No Do you have any type of thumb or tongue habit? \_\_\_\_\_  
Yes No Are you a mouth breather? \_\_\_\_\_  
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? \_\_\_\_\_  
Yes No Are you aware of your jaw clicking or popping? \_\_\_\_\_  
Yes No Are you aware of clenching your teeth during the day? \_\_\_\_\_  
Yes No Have you ever been told that you grind your teeth? \_\_\_\_\_  
Yes No Do you like the appearance of your smile? \_\_\_\_\_

## OFFICE POLICIES

**FEES** - The fee for your treatment is based on the complexity of your case. You will be informed of the fee after your examination.

**PAYMENT** - It is our policy that payment for all services rendered be made in full AT or BEFORE the completion of treatment. We realize that some dental treatment may be of an emergency nature, and that patients may not always be prepared for unexpected dental expenses. To assist you in this regard, we gladly accept VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS.

**DENTAL INSURANCE** - If you believe that your treatment is covered by a dental insurance policy, we will be happy to assist you in completing the necessary forms. Please understand that while this is done for your convenience, **we consider each patient to be responsible for their entire balance regardless of their insurance coverage.**

If your insurance carrier will reimburse you directly, we ask that your account with our office be paid in full when treatment is rendered.

If you request the insurance carrier to reimburse our dental office, we ask that 50% of the fee be paid when the insurance is submitted. Your account will be adjusted immediately if a credit balance is created after an insurance payment.

**MISSED APPOINTMENTS** - Confirmed appointments require 24 hour notice if you are unable to be present. You will be assessed a MISSED APPOINTMENT FEE (\$50 for HYGIENE VISIT and/or \$75 for DOCTOR VISIT.)

X \_\_\_\_\_  
Signature of patient (or parent, if minor)

\_\_\_\_\_  
Date

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