



Mooney Dental

Trusting Dental Care that You and Your Family can SMILE about

GENERAL INFORMED CONSENT

I, _____, consent to necessary diagnostic or preventative treatment provided by Dr. _____, including, but not limited to, diagnostic tests, cleanings, x-rays, exams, and any other procedure that is deemed necessary.

Patient Signature

Date



PATIENT INFORMATION

DATE: _____

EMAIL: _____

NAME: _____ PREFERRED FIRST NAME: _____

BIRTHDATE: ____/____/____ MARRIED SINGLE MINOR M/F ____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY # ____/____/____ BEST CONTACT PHONE # _____

PLACE OF EMPLOYMENT: _____ WORK# _____

IF FULL TIME STUDENT, COLLEGE NAME: _____

DENTAL INSURANCE CO: _____ SUBSCRIBER# _____ GROUP# _____

HAS ANY MEMBER OF YOUR FAMILY EVER BEEN TREATED IN OUR OFFICE? _____

WHOM MAY WE THANK FOR REFERRING YOU TO THE OFFICE? _____

IF MARRIED OR UNDER 18 PLEASE COMPLETE

FATHER (HUSBAND)

MOTHER (WIFE)

LAST FIRST M

LAST FIRST M

STREET CITY STATE ZIP

STREET CITY STATE ZIP

DOB

DOB

EMPLOYER

DENTAL INSURANCE SUBSCRIBER #

DENTAL INSURANCE SUBSCRIBER #

**PLEASE LIST EMERGENCY CONTACT
IF DIFFERENT FROM ABOVE:**

GUARANTOR

NAME

NAME

PHONE #

PHONE #

AUTHORIZATION

Professional care is provided to you, our patient, and not to an insurance company. If you have insurance, we will help you to determine the coverage you have available. We ask that you assign your insurance benefits to us. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We will help in every way we can in filing your claim and handling insurance questions from our office on your behalf. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

Patient signature (or if under 18, parent/guardian)

Date

Mooney Dental

10 Cedar Street
Unit 31
Woburn, MA 01801
781-281-9111

Dental History

Please help us to learn more about your dental history by answering the following questions. This series of questions is designed so that we are able to accommodate your specific dental needs.

- What did you like or dislike about your previous Dentist/Dental office?

- What is the approximate date of your last visit to the Dentist? _____

Dentist Name: _____

Please circle Yes or No to the following:

Do you feel nervous about having dental treatment?: YES / NO

Have you had any trouble associated with previous dental treatment?: YES / NO

Have you ever had gum treatments?: YES / NO

Are you unhappy with your smile?: YES / NO

Do you usually use 'novacaine' for dental treatment?: YES / NO

Missed Appointment Policy

We do our best to keep the cost of your dental treatment as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us with 48 hours notice, another patient who could have been seen was not. This adds to the overall cost of care, as trained personnel and dental facilities are not being utilized.

In the event you have three (3) missed appointments, we will be unable to afford to help you as a patient, considering the time we lose each time you fail to keep an appointment.

Initials _____

HIPAA

The Health Insurance Portability and Accountability Act

I, _____, have received and reviewed a copy of this office's notice of Privacy Practices.

Printed Name

Signature

Date

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No If yes

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____

Date: _____