



MOORESMILES

Family, Cosmetic & Implant Dentistry
ADAM MOORE, DDS

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____
First MI Last

Address _____ City _____ State _____ Zip _____

Birth Date _____ Home Phone # _____ Work Phone # _____ Email _____

Do you prefer to receive calls at: Home Work Either

Are you: Single Married Minor

You or your parents' employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse's or parent's name _____ Workplace _____ Work Phone # _____

If you are a student, name of school/college _____ City _____ State _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone # _____

Responsible Party

Name of person responsible for this account _____

Relationship to patient _____ Social Security # _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work Phone # _____

Insurance Information

Name of insured _____ Relationship to patient _____

Birth date _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Authorization

I certify that I have read and understand the dental/medical information to the best of my knowledge. The dental/medical questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

SIGNATURE OF PATIENT (Or parent if a minor)

DATE

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 "Yes" or "No" to indicate
 if you have any of the following:

Bad Breath Yes No
 Bleeding Gums Yes No
 Blisters on lips or mouth Yes No
 Burning sensation on
 tongue Yes No

Clicking or popping jaw Yes No

Dry Mouth Yes No

Food collection between
 teeth Yes No

Foreign Objects Yes No

Grinding Teeth Yes No

Gums swollen or tender Yes No

Jaw pain or tiredness Yes No

Lip or cheek biting Yes No

Loose teeth or broken
 fillings Yes No

Mouth breathing Yes No

Mouth pain, brushing Yes No

Orthodontic treatment Yes No

Partial(s) or Denture(s) Yes No

Periodontal treatment Yes No

Sensitivity to cold Yes No

Sensitivity to heat Yes No

Sensitivity to sweets Yes No

Sensitivity to biting Yes No

Sores or growths in the
 mouth Yes No

Smokeless Tobacco Yes No

Tobacco habit Yes No

How often do you floss? _____

How often do you brush? _____

Medical History

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS Yes No
 Anemia Yes No
 Anxiety/Panic Attacks Yes No
 Arthritis, Rheumatism Yes No
 Artificial Heart Valves Yes No
 Asthma Yes No
 Back Problems Yes No
 Bleeding abnormally with
 extractions or surgery Yes No
 Blood Disease Yes No
 Blood Thinner/Aspirin Yes No
 Cancer Yes No
 Chemical Dependency Yes No
 Chemotherapy Yes No
 Circulatory Problems Yes No
 Congenital Heart Lesions Yes No
 Cough, persistent or bloody Yes No
 Diabetes Yes No
 Emphysema Yes No
 Do you wear contact lenses Yes No
 Epilepsy Yes No
 Fainting or dizziness Yes No
 Glaucoma Yes No

Headaches Yes No
 Heart Murmur Yes No
 Heart Problems Yes No
 Hepatitis Yes No
 Type _____
 Herpes Yes No
 High Blood Pressure Yes No
 HIV Positive Yes No
 Jaundice Yes No
 Jaw Pain Yes No
 Joint Replacement Yes No
 Kidney Disease Yes No
 Liver Disease Yes No
 Low Blood Pressure Yes No
 Mitral Valve Prolapse Yes No
 Osteoporosis Yes No

If yes, are you taking medications such as
 Fosamax for this? Yes No

Pacemaker Yes No

Women:

Are you pregnant Yes No

Due Date _____

Are you nursing Yes No

Psychiatric Care Yes No
 Radiation Treatment Yes No
 Respiratory Disease Yes No
 Rheumatic Fever Yes No
 Scarlet Fever Yes No
 Shortness of Breath Yes No
 Sinus Trouble Yes No
 Skin Rash Yes No
 Special Diet Yes No
 Stroke Yes No
 Swelling of Feet or Ankles Yes No
 Swollen Neck Glands Yes No
 Thyroid Problems Yes No
 Tonsillitis Yes No
 Tuberculosis Yes No
 Tumor or growth on head
 or neck Yes No
 Ulcer Yes No
 Venereal Disease Yes No
 Weight Loss, unexplained Yes No
 Chronic Disease _____
 Other: _____

Medications

List medications you are currently taking:

Pharmacy Name _____

Phone _____

Allergies

Aspirin Local Anesthetic
 Barbiturates (Sleeping Pills) Penicillin
 Codeine Sulfa
 Iodine Other _____
 Latex _____



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Acknowledgement of Receipt of Notice of Privacy Practices

* You may refuse to sign this acknowledgement *

I, _____ have received a copy of this
office's Notice of Privacy Practices.

Please Print Name

Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify) _____

