matt mcgee, DDS, PC
FAMILY & COSMETIC DENTISTRY

welcome

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health.
Please fill out this form completely.
The better we communicate, the better we can care for you.

1 about you

Name _____

Preferred Name _____

○ Male ○ Female ○ Single ○ Married ○ Divorced
○ Widowed ○ Separated

Birthday ___/___/___ Age _____ SS # _____

Address _____

City_____ State_____ Zip _____

Email _____

Home # _____ Work # _____

Mobile #_____ Fax # _____

Whom may we thank for referring you? _____

Other family members seen by us _____

Last visit date_____

Employer Phone_____

Emp. Address _____

How long employed there? _____

spouse info

Name _____

Home # _____ Work # _____

Mobile #_____ Birthdate _____/___ /_____

Email _____

2 account info

person responsible for account

Name _____ Relation _____

Home # _____ Work # _____

Mobile #_____ Birthdate _____/___ /_____

Email _____

Billing Address _____

City_____ State_____ Zip _____

3 insurance

Provider Name _____

Provider Address _____

City_____ State_____ Zip _____

Phone #_____

Group # _____

ID # _____

Insured's Birthdate _____

Insured's Employer _____

Insured's Ph #_____

Insured's SS # _____

**ID# is sometimes different than SS#*

if you have a secondary insurance please let a team member know

4 reminder info

Because we know your life is busy, we use an electronic appointment reminder and messaging system.

Please check all that you prefer, as our best way to contact you.

○ Email Only ○ Text Message Only ○ Text Message & Email

5 reminder info

in the event of an emergency, who should we contact?

Name _____ Relation _____

Home #_____ Work # _____

Thank you for filling out this form completely. It will allow us to serve you more effectively. If you have a question at any time, please ask us. We are happy to help.

6 medical history

Do you have a personal physician? ○ Yes ○ No

Physician's Name _____

Phone # _____ Last visit date_____

Are you currently under the care of a physician? ○ Yes ○ No

Please explain_____

_____

Your current physical condition ○ Good ○ Fair ○ Poor

Do you smoke or use tobacco in any form? ○ Yes ○ No

Are you taking any prescription/over-the-counter or herbal supplement drugs? ○ Yes ○ No

Please list each one: _____

_____

_____

_____

Have you ever taken Phen-Fen? ○ Yes ○ No
(Also known as Redux or Pondimin) If yes, when?_____

Are you taking any medications for Osteoporosis? ○ Yes ○ No

If so, what?_____

are you allergic to any of the following?

Aspirin	Y N	Erythromycin	Y N	Penicillin	Y N
Codeine	Y N	Jewelry/Metals	Y N	Tetracycline	Y N
Dental Anesthetics	Y N	Latex	Y N	Other	Y N

Please list any other drugs/materials that you are allergic to:

_____

_____

have you ever had any of the following diseases or medical problems?

Abnormal Bleeding	Y N	Hepatitis	Y N
Alcohol / Drug Abuse	Y N	Herpes/Fever Blisters	Y N
Anemia	Y N	High Blood Pressure	Y N
Arthritis	Y N	HIV+ / AIDS	Y N
Artificial Bones, Joints, or Valves	Y N	Hospitalized (any reason)	Y N
		Kidney Problems	Y N
Asthma	Y N	Liver Disease	Y N
Blood Transfusion	Y N	Low Blood Pressure	Y N
Cancer/Chemotherapy	Y N	Lupus	Y N
Colitis	Y N	Mitral Valve Prolapse	Y N
Congenital Heart Defect	Y N	Pacemaker	Y N
Diabetes	Y N	Psychiatric Problems	Y N
Difficulty Breathing	Y N	Radiation Treatment	Y N
Emphysema	Y N	Rheumatic/Scarlet Fever	Y N
Epilepsy	Y N	Seizures	Y N
Fainting Spells	Y N	Shingles	Y N
Frequent Headaches	Y N	Sickle Cell Disease	Y N
Glaucoma	Y N	Sinus Problems	Y N
Hay Fever	Y N	Stroke	Y N
Heart Attack	Y N	Thyroid Problems	Y N
Heart Murmur	Y N	Tuberculosis (TB)	Y N
Heart Surgery	Y N	Ulcers	Y N
Hemophilia	Y N	Venereal Disease	Y N

Please list any medical condition(s) that you have ever had:

_____

_____

medical history cont.

Do you have trouble sleeping? ○ Yes ○ No

Do you feel tired or fatigued after sleep? ○ Yes ○ No

Do you feel like you get enough sleep at night? ○ Yes ○ No

Do you have a CPAP? ○ Yes ○ No

If so, do you wear it? ○ Yes ○ No

for women only

Are you taking birth control pills? ○ Yes ○ No

Are you pregnant? ○ Yes ○ NoWeek #_____

Are you nursing? ○ Yes ○ No

7 dental history

Why have you come to the dentist today?

_____

_____

Has your doctor told you that you require antibiotics before dental treatment? ○ Yes ○ No

Are you currently in pain? ○ Yes ○ No

Have you ever had a serious/difficult problem associated with any previous dental work? ○ Yes ○ No

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ○ Yes ○ No

Your current dental health is ○ Good ○ Fair ○ Poor

Do you like your smile? ○ Yes ○ No

Do your gums ever bleed? ○ Yes ○ No

How many times a week do you floss? _____

How many time a day do you brush? _____

Type of toothbrush bristles? ○ Hard ○ Medium ○ Soft

8 disclaimer

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

In the event that payment in full for charges incurred is not made, I agree to pay all costs of collection including a 50% collection fee, attorney fees, and court costs.

_____
Signature Date

_____
Print

payment is due in full at time of treatment unless prior arrangements have been approved.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.