



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.

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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	Y N	Latex	Y N	Other	Y N
Anesthetics	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
Asthma	Y N	Kidney Problems	Y N
Blood Transfusion	Y N	Liver Disease	Y N
Cancer/Chemotherapy	Y N	Low Blood Pressure	Y N
Colitis	Y N	Lupus	Y N
Congenital Heart Defect	Y N	Mitral Valve Prolapse	Y N
Diabetes	Y N	Pacemaker	Y N
Difficulty Breathing	Y N	Psychiatric Problems	Y N
Emphysema	Y N	Radiation Treatment	Y N
Epilepsy	Y N	Rheumatic/Scarlet Fever	Y N
Fainting Spells	Y N	Seizures	Y N
Frequent Headaches	Y N	Shingles	Y N
Glaucoma	Y N	Sickle Cell Disease	Y N
Hay Fever	Y N	Sinus Problems	Y N
Heart Attack	Y N	Stroke	Y N
Heart Murmur	Y N	Thyroid Problems	Y N
Heart Surgery	Y N	Tuberculosis (TB)	Y N
Hemophilia	Y N	Ulcers	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 No Week # _____

Are you nursing? Yes No

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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

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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.