Merryman Family Dentistry

92 Broad Street

Schuylerville, NY 12871

(518)695-9015

dr.merryman@merrymanfamilydentistry.com

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_

Land Line Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ꙱ Preferred Contact

Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ꙱ Preferred Contact

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Confirmation Method: ꙱ Phone ꙱ Text ꙱ Email

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

꙱ Married ꙱ Single ꙱Widowed ꙱Divorced ꙱ Student

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ꙱ Retired

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ꙱ Preferred Contact

Dental Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Info: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*Please present card/s to be scanned.**

**Allergies:** ꙱ Sulfa ꙱ Penicillin ꙱ Dental Anesthesia

 ꙱ Foods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ꙱ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Alerts:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Joint or Valve Replacement:** YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Premedication Required:** YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 -Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 -Last Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Prescription Drugs: (you may give us a list to copy/scan)**

|  |  |  |
| --- | --- | --- |
| Drug Name | Dose | Used For |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Pharmacy Name and Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you in good health? YES NO

Any health changes in the last year? YES NO

 What change? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recent Weight gain or loss? YES NO

Currently under a physician’s care? YES NO

 What for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abuse of drugs or alcohol? YES NO

History of depression or psychiatric care? YES NO

History of tobacco use? YES NO

 Amount: \_\_\_\_\_ How long: \_\_\_\_\_\_\_\_\_ Quit: YES NO

History of Hospitalization? YES NO

 Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Health History**

Purpose of visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have pain? YES NO Area in mouth? :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Dental Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check all that apply.**

|  |  |  |  |
| --- | --- | --- | --- |
| Dental Anxiety |  | Migraines or Facial Pain |  |
| Bleed with Brushing and Flossing |  | Accident or Injury to Head and/or Neck |  |
| Gag Reflex |  | TMJ Therapy or Treatment |  |
| Gums Tender or Swollen |  | Tired Jaw |  |
| Lumps or Growths |  | Teeth Loosened or Shifting |  |
| Canker or Cold Sores |  | Clench/Grind Teeth |  |
| Swallowing Difficulty |  | Persistent Dry Mouth |  |
| Sensitive Teeth -Temperature -Sweets |  | Actively Play Musical Instruments |  |
| Difficult to get Numb |  | Periodontal Surgery (gums) |  |
| Sip Drinks Through the Day |  | Oral Surgery |  |
| Drink Energy Drinks Daily |  | Endodontics (root canal) |  |
| Chew on One Side |  | Orthodontics (braces) |  |

**Please check any medical conditions which apply.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Heart/Blood Vessels** | **Y** | **N** | **Muscles and Bones** | **Y** | **N** |
| AIDS/HIV |  |  | Arthritis |  |  |
| Angina/Chest |  |  | Gout |  |  |
| Artificial Valve |  |  | Osteoporosis/Osteopenia |  |  |
| High Cholesterol |  |  | Taking Bisphosphonates-Fosamax -Actonel -Boniva |  |  |
| Heart Murmur |  |  | **Respiratory** |  |  |
|  -Premed Needed |  |  | Asthma/Breathing Problems |  |  |
| Blood Transfusion |  |  | COPD |  |  |
| Heart Attack/Heart Failure |  |  | Sinus Problems |  |  |
| Pacemaker/Atrial Fibrillation |  |  | Lung Disease |  |  |
| Heart Disease/Endocarditis |  |  | Emphysema |  |  |
| High or Low Blood Pressure |  |  | Tuberculosis |  |  |
| Irregular Heartbeat |  |  | Frequent Cough |  |  |
| Mitral Valve Prolapse |  |  | Difficulty Breathing Lying Down |  |  |
| Shortness of Breath |  |  | Sleep Apnea |  |  |
| Heart Related Surgeries |  |  | Loud Snoring |  |  |
| **Blood** |  |  | Acid Reflux/Antacids Regularly |  |  |
| Blood Thinners |  |  | **Endocrine** |  |  |
| Blood Disease |  |  | Diabetes |  |  |
| Lyme Disease |  |  | Thyroid/Goiter, Graves Condition |  |  |
| Anemia |  |  | Low or High Blood sugar |  |  |
| Excessive Bleeding/Clotting |  |  | **Intestinal/Urinary System** |  |  |
| Hemophilia |  |  | Hepatitis |  |  |
| Bruise Easily |  |  | Jaundice |  |  |
| **Neurological** |  |  | Ulcers |  |  |
| Stroke |  |  | Frequent Diarrhea |  |  |
| Frequent Headaches |  |  | Genital Herpes |  |  |
| Seizures/Convulsions |  |  | Kidney Disease |  |  |
| Fainting Spells, Dizziness, Vertigo |  |  | Venereal Disease |  |  |
| **Cancer** | **Y** | **N** | **Women Only** | **Y** | **N** |
| History of Tumor or Growth |  |  | Pregnant or Nursing |  |  |
| Chemotherapy |  |  | Trying to Become Pregnant |  |  |
| Radiation Therapy |  |  | Taking Hormones |  |  |
| CAT Scan/MRI/Ultrasound |  |  | Using Birth Control |  |  |
| Cancer Related Surgeries |  |  | Yeast Infections with Antibiotics |  |  |
| **Taking the Following** |  |  |  |  |  |
| Steroids in Last 2 Years |  |  |  |  |  |
| Vitamins/Herbs/Supplements |  |  |  |  |  |
| Non-Prescription Drugs Regularly |  |  |  |  |  |

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I understand that that the office of Merryman Family Dentistry does not participate with any insurance companies and that claims will be submitted by the office for “out of network” reimbursement. I also understand that fees are due at the time of service and that I am responsible for accrued fees and payment schedules which I have agreed to.

Patient Name Printed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **FOR PROVIDER USE** |
| Provider | Date |
|  |  |
|  |  |