Merryman Family Dentistry

92 Broad Street

Schuylerville, NY 12871

(518)695-9015

[dr.merryman@merrymanfamilydentistry.com](mailto: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

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 accordingly.**

|  |  |  |  |
| --- | --- | --- | --- |
| Dental Anxiety |  | Migraines or Facial Pain |  |
| Bleed with Brushing and Flossing |  | Accident or Injury to Head and/or Neck |  |
| Gag Reflex |  | TMJ Issues/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 all medical conditions accordingly.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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 |  |  |
| Blood Pressure --High or Low |  |  | 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Are you a veteran of the armed forces? \_\_\_\_ Yes \_\_\_\_ No

I understand that that the office of Merryman Family Dentistry does not participate with any insurance companies and that most claims will be submitted by the office for “out of network” reimbursement. Medicare claims must be submitted by the patient. 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 |
|  |  |
|  |  |