

Welcome to a Brighter Morgantown!

New Patient Information



MORGANTOWN
DENTAL GROUP



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DENTAL GROUP

EXCELLENCE IN DENTISTRY SINCE 1927

Welcome to Our Practice

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

ABOUT YOU

Today's Date: ____ / ____ / ____

Name: _____

(Last, First, MI)

Name I prefer: _____

Male Female

Birthdate: ____ / ____ / ____ Age: ____ Social Security #: ____

Home Address: _____

(Address, Street Apt/Condo#)

(City)

(State)

(Zip)

Single Married Child

CONTACT INFORMATION

Home Phone #: _____ Cell #: _____

Email address: _____

Work #: _____ EXT: _____

Employer:

Employer's Address: _____

(Address, Street Apt/Condo#)

(City)

(State)

(Zip)

Occupation: _____

Where & When is the best time to reach you? _____

EMERGENCY CONTACT INFORMATION

In the event of an emergency, is there someone who lives near you that we should contact? Yes No

Their Name: _____

Relation: _____

Work #: _____

Home #: _____

NEW PATIENTS ONLY

Whom may we thank for referring you?: _____

Other family members seen by us: _____

Previous/Present Dentist: _____

Last Visit Date: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____
(Last, First, MI)

Name I prefer: _____ Male Female

Birthdate: ____ / ____ / ____ Age: ____ Social Security #: ____ - ____ - ____

Home Address: _____
(Address, Street Apt/Condo#) (City) (State) (Zip)

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

If No, Please Explain: _____

Employer: _____

SPOUSE OR PARENTAL INFORMATION

Name: _____
(Last, First, MI)

Employer: _____ Work/EXT#: _____

Home Phone #: _____

Birthdate: ____ / ____ / ____ Age: ____ Social Security #: ____ - ____ - ____

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: : _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Federal Employees R#: _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____ / ____ / ____ Insured's Social Security #: ____ - ____ - ____

Insured's Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Federal Employees R#: _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____ / ____ / ____ Insured's Social Security #: ____ - ____ - ____

Insured's Employer: _____

MEDICAL HISTORY

Do you have a personal a physician? Yes No

Physician's Name: _____ Phone #: _____

Date of Last Visit: _____

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

If No, Please Explain: _____

Do you smoke or use tobacco products? Yes No

Have you ever had any of the following diseases or medical problems? Yes No

YES NO Heart Attack/Stroke

YES NO Cancer/Chemotherapy

YES NO Heart Murmur

YES NO Heart Surgery/Pacemaker

YES NO Mitral Valve Prolapse

YES NO Artificial Bones/Joints

YES NO Artificial Valves/Vascular Shunts

YES NO Congenial Heart Defect

YES NO Rheumatic Fever

YES NO HIV+/AIDS

YES NO Shingles

YES NO Kidney Problems

YES NO Sinus Problems

YES NO High/Low Blood Pressure

YES NO Thyroid Disease

YES NO Severe/Frequent Headaches

YES NO Psychiatric Problems

YES NO Epilepsy/Seizures/Fainting Spells

YES NO Diabetes/Tuberculosis (TB)

YES NO Drug/Alcohol Abuse

YES NO Venereal Disease

YES NO Hemophilia/Abnormal Bleeding

YES NO Ulcers/Colitis

YES NO Anemia/Radiation Treatment

YES NO Asthma/Arthritis

YES NO Difficulty Breathing

YES NO Hospitalized for any Reason

YES NO Hepatitis

YES NO Blood Transfusion

YES NO Emphysema/Glaucoma

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

List any medicine you are currently taking (including non-prescription medicines, vitamins, and herbal supplements): _____

Are you allergic to any of the following drugs? Yes No

YES NO Penicillin

YES NO Aspirin

YES NO Erythromycin

YES NO Tetracycline

YES NO Dental Anesthetics

YES NO Codeine

YES NO Latex

YES NO Other

Please list any other drugs that you are allergic to: _____

FOR WOMEN ONLY

Are you taking birth control pills? YES NO Are you pregnant? YES NO

Week #: _____

Are you nursing? YES NO

