KATHLEEN MULLANEY
DDS · FAGD

Welcome

We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are immeasurable, and our goal is to help you obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so we can provide the best care possible for you.

Thank you!

About you

Name (first, MI, last) ______________________________

How would you like to be addressed? ______________________________

How did you hear about Dr. Mullaney? ______________________________

Address ______________________________

City ____________________ State __________ Zip __________

Day phone ____________________ Evening phone ____________________

Mobile phone ____________________ Emergency Contact number ____________________

Email ______________________________

Social Security Number ____________________ Date of Birth ____________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed

More about you:

Occupation ____________________

Employer ____________________

Address ____________________

Phone ____________________

About your spouse:

Name ____________________

Occupation ____________________

Employer ____________________

Address ____________________

Phone ____________________

Insurance information

Name of insured ______________________________

Relation to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer ______________________________

Employer Address ______________________________

City ____________________ State __________ Zip __________

Insurance company ______________________________

Insurance co. address ______________________________

City ____________________ State __________ Zip __________

Carrier ID ____________________ Group # ____________________

Insured Social Security Number ____________________ Date of Birth ____________________

Medical History

Name ______________________________

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Name of physician/specialist and their speciality ______________________________
Physician address ______________________________
______________________________ Phone ______________

Most recent doctor's visit and purpose ______________________________

Please answer YES or NO to the following:
DO YOU HAVE OR HAVE YOU EVER HAD:

	YES	NO
1. Hospitalization for illness or injury	☐	☐
2. An allergic reaction to:		
Aspirin, ibuprofen, acetaminophen, codeine	☐	☐
Penicillin	☐	☐
Erythromcin	☐	☐
Tracycline	☐	☐
Sulpha	☐	☐
Local anesthetic	☐	☐
Fluoride	☐	☐
Metals (nickel, gold, silver, ...)	☐	☐
Latex	☐	☐
Other ______________	☐	☐
3. Heart problems, or cardiac stent within the last 6 months	☐	☐
4. History of infective endocarditis	☐	☐
5. Artificial heart valve, repaired heart defect (PFO)	☐	☐
6. Pacemaker or implantable defibrillator	☐	☐
7. Artifical prosthesis (heart valve or joints)	☐	☐
8. Rheumatic or scarlet fever	☐	☐
9. High or low blood pressure	☐	☐
10. A stroke (taking blood thinners)	☐	☐
11. Anemia or other blood disorder	☐	☐
12. Prolonged bleeding due to a slight cut (INR > 3.5)	☐	☐
13. Emphysema, srcoidosis	☐	☐
14. Tuberculosis	☐	☐
15. Asthma	☐	☐
16. Breathing or sleep problems (i.e. snoring, sinus)	☐	☐
17. Kidney disease	☐	☐
18. Liver disease	☐	☐
19. Jaundice	☐	☐
20. Thyroid, parathiroid disease or calcium deficiency	☐	☐
21. Hormone deficiency	☐	☐
22. High cholesterol or taking statin drugs	☐	☐
23. Diabetes (HbA1c=______________)	☐	☐
24. Stomach or duodenal ulcer	☐	☐

	YES	NO
25. Digestive disorders (and/or gastric reflux)	☐	☐
26. Osteoporosis/osteopenia (i.e. taking bisphosphonates)	☐	☐
27. Arthritis	☐	☐
28. Glaucoma	☐	☐
29. Contact lenses	☐	☐
30. Head or neck injuries	☐	☐
31. Epilepsy, convulsions (seizures)	☐	☐
32. Neurolgic problems (attention deficit disorder)	☐	☐
33. Viral infections and cold sores	☐	☐
34. Any lumps or swelling in the mouth	☐	☐
35. Mouth ulcers, fever blisters	☐	☐
36. Hives, skin rash, hay fever	☐	☐
37. Venereal disease	☐	☐
38. Positive for HPV	☐	☐
39. Hepatitis (type _____)	☐	☐
40. HIV / AIDS	☐	☐
41. Tumor, abnormal growth	☐	☐
42. Radiation therapy	☐	☐
43. Chemotherapy	☐	☐
44. Emotional problems	☐	☐
45. Psychiatric treatment	☐	☐
46. Antidepressant medication	☐	☐
47. Alcohol/drug dependency	☐	☐
Are you?		
48. Presently being treated for any other illness	☐	☐
49. Aware of a change in your health in the last 24 hours	☐	☐
(Fever, chills, new cough or diarrhea)	☐	☐
50. Taking medication for weigh management (i.e. fen-phen)	☐	☐
51. Taking dietary supplements	☐	☐
52. Often exhausted or fatigued	☐	☐
53. Subject to frequent headaches	☐	☐
54. A smoker or smoked previously	☐	☐
55. Often unhappy or depressed	☐	☐
56. FEMALE - taking birth control pills	☐	☐
57. FEMALE - pregnant	☐	☐
58. MALE - prostate disorders	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications, supplements, and/or vitamins taken within the last two years. (Drug and purpose) Continue on back as needed.

Please advise us in the future of any change in your medical history, or in the medications you are taking.

Patient's Signature Date
____

Doctor's Signature Date
____

Dental History

Name ______________________________

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How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist ______________________________

How long have you been a patient? Months _______ Years _______

Date of most recent dental exam ______________________

Date of most recent x-rays ______________________

Date of most recent treatment (other than a cleaning) ______________________

I routinely see my dentist every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

What is your immediate concern? ____

Please answer YES or NO to the following: *YES NO*

PERSONAL HISTORY

1. Are you fearful of dental treatment? . . . . ☐ ☐
   If so, how fearful, on a scale of 1 (least) to 10 (most) ________
2. Have you had an unfavorabe dental experience? . . . . ☐ ☐
3. Have you ever had complications from past dental treatment? ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? . . . . ☐ ☐
5. Did you ever have braces, orthodontic treatment or have your bite adjusted? . . . . ☐ ☐
6. Have you had any teeth removed? . . . . ☐ ☐

GUM AND BONE

7. Do your gums bleed when brushing or flossing? . . . . ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? . . . . ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? . . . . ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? . . . . ☐ ☐
11. Have you ever experienced gum recession? . . . . ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury) or do you have difficulty eating an apple? ☐ ☐
13. Have you experienced a burning sensation in your mouth? ☐ ☐

BITE AND JAW JOINT

14. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) . . . . ☐ ☐
15. Do you/would you have any problems chewing gum? . . . . . ☐ ☐
16. Do you/would you have any problems chewing bagels, baguettes, protein bars or other hard foods? . . . . ☐ ☐
17. Have your teeth changed in the last 5 years, become shorter, thinner or worn? . . . . ☐ ☐
18. Are your teeth crowding or developing spaces? . . . . ☐ ☐

YES NO

19. Do you have more than one bite and squeeze to make your teeth fit together? . . . . ☐ ☐
20. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? . . . . ☐ ☐
21. Do you clench your teeth in the daytime or make them sore? ☐ ☐
22. Do you have any problems with sleep or wake up with an awareness of your teeth? . . . . ☐ ☐
23. Do you wear or have you ever worn a bite appliance? . . . . . ☐ ☐

TOOTH STRUCTURE

24. Have you had any cavities within the past 3 years? ☐ ☐
25. Does the amount of saliva in your mouth seem too little, or do you have difficulty swallowing any food? . . . . ☐ ☐
26. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? . . . . ☐ ☐
27. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? . . . . ☐ ☐
28. Do you have grooves or notches on your teeth near the gum line? . . . . ☐ ☐
29. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? . . . . ☐ ☐
30. Do you get food caught between any teeth? . . . . ☐ ☐

SMILE CHARACTERISTICS

31. Is there anything about the appearance of your teeth that you would like to change? . . . . ☐ ☐
32. Have you ever whitened (bleached) your teeth? . . . . ☐ ☐
33. Have you felt uncomfortable or self-conscious about the appearance of your teeth? . . . . ☐ ☐
34. Have you been disappointed with the appearance of previous dental work? . . . . ☐ ☐

Patient's Signature ______________________________ Date ______________

Doctor's Signature ______________________________ Date ______________

Your Consent

KATHLEEN MULLANEY
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I hereby authorize Dr. Kathleen Mullaney and her team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Dr. Mullaney to make a thorough diagnosis of ____dental needs.

Upon such diagnosis, I authorize Dr. Mullaney to perform all recommended treatment mutually agreed upon by me, and to employ assistance as required upon to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to Dr. Mullaney and her team for use and disclosure of any oral, written or electronic health records that are individually identifiable as belonging to the patient named herein for the purpose of carrying out the treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed, and that a notice fully outlining the protection of my personal health information is also available.

I understand that the responsibility for payment for dental services provided in this office for myself or my dependents in mine, due and payable at the time services are rendered unless financial arrangements have been made. in the event of default, I promise to pay legal interest (1.5% per month - 18% per annum), together with any collection costs and attorney fees as may be required to effect collection of this note.

Patient's Signature   Date

____ _________________________________

Witness ____

Responsible Party's Signature ____

Relationship to Patient ____