Patient Health Record

Welcome to the office of Robert F. Murray, D.D.S.

In order for me to render the proper dental services, Please answer the following questions. Please note the space for remarks, clarification or any other information you think I should have to server you. Thank you.

Patient Information

Date _____

Home Phone #_____

Name_____Cell Phone # _____
Last Name First Name Initial

Address_____Email _____

City_____**Soc. Sec. #**_____

State _____ Zip _____ Sex M __ F ___ Age _____ Birth Date _____

Circle: Single____ Married____ Widowed____ Separated ____ Divorced____ Student __ FT __ PT __

Patient Employed by _____ Occupation_____ Name of School _____

Business Address _____ Business Phone # _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone # _____

Responsible Party (who pays your bills?)

Name of Person Responsible for this account _____ Relationship to patient _____

Address _____ Home Phone # _____

Drivers License #_____State ___ Employer _____ Business Phone # _____

Financial Institution _____ Birth Date _____ **Soc. Sec. #**_____

Medical Health

General Health Excellent Good Fair

Name of Physician _____ Phone # _____ Last complete physical _____/_____/_____

Are you under the care of a physician now? Yes ____ No _____ If yes, describe the purpose _____

Are you taking medication now? (If so, what?) _____

Are you allergic to: Penicillin □ Local anesthetics □ Any other medications? _____

For office use:

Have you had any serious illness or operation? _____ HH-Update: _____ _____ _____ _____

Have you been hospitalized in the past five years? _____ _____ _____ _____ _____

Women are you pregnant? Yes □ No □ How many months? _____ _____ _____ _____ _____

Check if you have ever been told or treated for any of the following conditions:

Heart disease	Yes □	No □	Tuberculosis or lung disease	Yes □	No □	Sinus trouble	Yes □	No □
Heart murmur/MVP	Yes □	No □	Diabetes	Yes □	No □	Latex Allergy	Yes □	No □
Artificial Heart Valve	Yes □	No □	Controlled	Yes □	No □	Arthritis	Yes □	No □
Artificial Joints	Yes □	No □	How often? _____			Glaucoma	Yes □	No □
Stroke	Yes □	No □	Epilepsy	Yes □	No □	Nervous disorders	Yes □	No □
Pacemaker	Yes □	No □	Cancer	Yes □	No □	Prolonged bleeding	Yes □	No □
Rheumatic fever	Yes □	No □	Thyroid	Yes □	No □	Fainting spells	Yes □	No □
High blood pressure	Yes □	No □	Kidney/Liver Disease	Yes □	No □	Chemical Dependency	Yes □	No □
Congenital heart lesions	Yes □	No □	Hepatitis	Yes □	No □	HIV and/or AIDS	Yes □	No □
Ulcers	Yes □	No □	Asthma or Hay Fever	Yes □	No □	Bisphosphonates	Yes □	No □

Dental History

Reason for today's visit _____

Former Dentist _____ Phone _____ Email _____

Reason for leaving former dentist _____

Date of last dental care _____ Date of last dental x-rays _____

How often do you floss? _____ How often do you brush? _____

Primary Dental Insurance

Insurance Company _____ Group # _____

Subscriber Name _____ **Soc. Sec. #** _____
Last name First name

Relationship to patient _____Birth Date _____ Drivers License #_____State _____

Address (if different form patient) _____ Home Phone # _____

_____ City _____State _____ Zip _____

Subscriber Employed by _____ Occupation _____

Business Address _____ Business Phone # _____ Contact _____

Name of other dependents covered under this plan _____

Secondary (additional) Dental Insurance

Is patient covered by additional insurance? Yes □ No □

Insurance Company _____ Group # _____

Subscriber Name _____ **Soc. Sec. #** _____
Last name First name

Relationship to patient _____Birth Date _____ Drivers License #_____State _____

Address (if different form patient) _____ Home Phone # _____

_____ City _____ State _____ Zip _____

Subscriber Employed by _____ Occupation _____

Business Address _____ Business Phone # _____Contact # _____

Name of other dependents covered under this plan _____

Authorization for Dental Treatment and Release to Insurance

I authorize and give consent to Dr. Murray and his staff to perform dental treatment, including but not limited to, local anesthesia, analgesia and other such treatment, which may be necessary for the above named patient. I also understand that the use of these agents and some procedures embody a certain risk. I certify that I have read and understand the above information to the best of my knowledge. The questions above have been answered accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such Dental Care to third party payors and/or health practitioners.
I authorize and request my insurance company to pay directly to the dentist or dental group insurance otherwise payable to me.
I understand that my dental insurance carrier may pay less than the actual bill for services rendered.
I am aware that I am responsible for payment of all services rendered on my behalf and of my dependents.

X _____
Signature of patient (or parent if minor patient)

Who does minor child live with more than 50% per year? (Please provide full name if different from child's name)
Mother _____Father _____ Other _____
I have answered all the above questions to the best of my ability.

I consent to the taking of radiographs and/or photographs before and during treatment for diagnostic purposes and for the use by Dr. Murray in scientific papers or demonstrations. Sign_____

I consent to the publication of my photos by Dr. Murray. Sign_____