RICHARD A. MURDOCH, D.D.S.
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information@murdochdds.com

PLEASE PRINT

PATIENT NAME:		BIRTHDATE:
ADDRESS:		
CITY, STATE, ZIP:	EMAIL ADDRESS:	SOCIAL SECURITY #:
PATIENT EMPLOYER:		HOME PHONE:
BUSINESS ADDRESS:		WORK PHONE
JOB TITLE:		CELL PHONE

MARITAL STATUS:	SPOUSES NAME:	BIRTHDATE:
ADDRESS (IF DIFFERENT):		PHONE:
SPOUSE EMPLOYER:	SOCIAL SECURITY #:	
BUSINESS ADDRESS:		PHONE:
JOB TITLE:		

ACCOUNT INFORMATION	
RESPONSIBLE PARTY FOR THIS ACCOUNT:	RELATIONSHIP TO PATIENT:
ADDRESS (IF DIFFERENT):	PHONE:
CITY, STATE, ZIP:	SOCIAL SECURITY #:
PRIMARY DENTAL INSURANCE, CARRIER NAME:	
INSURANCE ADDRESS:	
POLICYHOLDER NAME:	GROUP #:
SECONDARY DENTAL INSURANCE, CARRIER NAME:	
INSURANCE ADDRESS	
POLICYHOLDER NAME:	GROUP #:

EMERGENCY CONTACT: _____

NEAREST RELATIVE: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

PAYMENT CONTRACT

I understand that I am financially responsible for the services received. Payment will be due at each appointment. Balances extending over 30 days will incur a 1 1/2% finance charge per month unless other arrangements are made. Patient agrees to pay collection costs, including reasonable attorney's fees should the account go delinquent. A fee will be charged for appointments cancelled with less than 24 hours notice.

_____

SIGNATURE: RESPONSIBLE PARTY DATE

Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you, the office of Richard Murdoch DDS to use and disclose my protected health information to carry out:

- Treatment (including direct/indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations for your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carryout treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Do we have your permission to:
Send a recall appointment reminder to your home? Yes_____No_____

Leave appointment billing or dental information on your answering machine/voice mail/e-mail
Yes_____No_____

I give permission to share appointment, billing or dental information with these person(s):

Named:_____Relationship:_____Phone:#_____

Named:_____Relationship:_____Phone:#_____

My Personal Contact Information is:

My home answering machine or voice mail number**:** ( )_____

My cell phone voice mail number ( )_____

My Work voice mail number**:** ( )_____

Signed this _____ day of _____, 20_____.

Print Patient Name:_____

Relationship to Patient:_____

Signature:_____

PATIENT MEDICAL HISTORY

Name_____ **Responsible Party**_____

Home Phone #_____ **Cell #**_____ **Email Address**_____

I prefer my appointments to be confirmed using:

☐ **Phone #**_____ ☐**Email** ☐ **Text Cell Phone Provider (e.g. A&T)**_____

Personal Physician_____ **Office Phone**_____

	YES	NO
1. **Are you under any medical treatment at this time?**.....	☐	☐
2. **Have you had any major operations in the past two years?**.....	☐	☐
3. **Have you taken any medicine or drugs during the past 2 years?**.....	☐	☐
List your Current Medications:_____		
4. **Are you allergic to (i.e. itching, rash, swelling of hands/feet/eyes) or made sick by**		
Penicillin, aspirin, codeine, or any other medications?.....	☐	☐
5. **Are you allergic to metals, plastics or latex?**.....	☐	☐
6. **Have you ever had excessive bleeding requiring special treatment?**.....	☐	☐
7. **Do you have orthopedic appliances, (i.e. Hip or Knee replacement or bone pin)?**	☐	☐
Date(s)_____		
8. **Women: Are you pregnant right now or is there a chance you might be?**.....	☐	☐
Are you presently practicing birth control?.....	☐	☐

9. **Check any of the following you have had or presently have:**

__	Abnormal Bleeding	__	Congenital Heart Lesions	__	Heart Murmur	__	Pneumocystis
__	Acid Reflux	__	Cortisone Medicine	__	Heart Surgery	__	Psychiatric Treatment
__	Alcohol Abuse	__	Cosmetic Surgery	__	Hemophilia	__	Radiation Therapy
__	Allergies	__	Crohn's Disease	__	Hepatitis A	__	Rheumatic Fever
__	Anemia	__	Diabetes	__	Hepatitis B	__	Shingles
__	Angina Pectoris	__	Drug Abuse	__	Hepatitis C	__	Sickle Cell Disease
__	Arthritis/Rheumatism	__	Emphysema	__	High Blood	__	Sinus Problems
__	Artificial Bones	__	Epilepsy or Seizures	__	High Cholesterol	__	Stroke
__	Artificial Heart Valve	__	Fainting or Dizzy	__	HIV Positive or	__	Thyroid Problems
__	Asthma	__	Fever Blister/Cold	__	Kidney Trouble	__	Tobacco Use
__	Blood Transfusion	__	Frequent Headaches	__	Liver Disease	__	Tuberculosis
__	Bronchitis	__	Glaucoma	__	Low Blood Pressure	__	Venereal Disease
__	Cancer	__	Hay Fever	__	Marijuana User	__	X-ray/Cobalt Treatment
__	Chemotherapy	__	Heart Attack	__	Mitral Valve Prolapse	__	Yellow Jaundice
__	Colitis	__	Heart Disease	__	Pace Maker	__	

10. **List any other conditions you have that are not listed above**

_____

_____

Patient Dental History

	YES	NO
11. Are you currently or have you been experiencing pain in your face or mouth?.....	☐	☐
12. Do your gums ever bleed?.....	☐	☐
13. Have you noticed any loose teeth?.....	☐	☐
14. Have you noticed any bad odors or tastes coming from your mouth?.....	☐	☐
15. Are you satisfied with the appearance of your teeth?.....	☐	☐
16. Are your teeth sensitive to hot, cold, sweets, brushing, or biting pressure?.....	☐	☐
17. Have you ever had orthodontic (braces) treatment?	☐	☐
18. Have you ever had periodontal (gum) treatment?.....	☐	☐
19. Does your jaw click or hurt when you chew?.....	☐	☐
20. Do you ever have pain in the region in front of your ears?	☐	☐
21. Do you clench or grind your teeth in the daytime or while you sleep?	☐	☐
22. Do you wear a mouth guard or bite appliance?.....	☐	☐
23. In your opinion do you take good care of your teeth?.....	☐	☐
24. Are you apprehensive about dental treatment?.....	☐	☐
25. Do you smoke or chew tobacco?	☐	☐

If yes, how often?_____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health or medication, I will inform the dentist at my next appointment.

Patient Signature:

_____ **Date:**_____

Health History Updates (for office use)

Date:_____ **No change:**_____ **Changes noted on form:**_____ **Patient Initials:**_____

Date:_____ **No change:**_____ **Changes noted on form:**_____ **Patient Initials:**_____