Welcome to Dr. Maloney's Office

Date:_____ PLEASE PRINT

Patient Name:_____
Last Name First Name Middle Initial Preferred Name

Street Address:_____ City:_____ State:_____ Zip:_____

Sex: ☐M ☐F Age:_____ Birthdate:_____ ☐Married ☐Widowed ☐Single ☐Minor

E-mail:_____ ☐Separated ☐Divorced ☐Partnered for ____ yrs.

Spouse/Parent Name:_____ Birthdate:_____ S.S. #:_____

Phone Numbers

Home: (_____)_____ Work: (_____)_____ Ext._____ Cell Phone: (_____)_____

Spouse's Work: (_____)_____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name & Relationship:_____ Phone: (_____)_____

Patient Employer/School:_____ Occupation:_____

Patient Employer/School Address:_____ Employer/School Phone: (_____)_____

Spouse/Parent Employed by:_____ Occupation:_____

Whom May We Thank For Your Referral:_____

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

Physician's Name:_____ Date of last visit:_____

Have you had any serious illnesses or operations? ☐Yes ☐No If yes, describe:_____

Have you ever had a blood transfusion? ☐Yes ☐No If yes, give approximate dates_____

(Women) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

Check (✓) if you have or have had any of the following:

☐Anemia	☐Cortisone Treatments	☐Hepatitis	☐Scarlet Fever
☐Arthritis, Rheumatism	☐Cough, Persistent	☐High Blood Pressure	☐Shortness of Breath
☐Artificial Heart Valves	☐Cough up Blood	☐HIV/AIDS	☐Skin Rash
☐Artificial Joints	☐Diabetes	☐Jaw Pain	☐Stroke
☐Asthma	☐Epilepsy	☐Kidney Disease	☐Swelling of Feet/Ankles
☐Back Problems	☐Fainting	☐Liver Disease	☐Thyroid Problems
☐Blood Disease	☐Glaucoma	☐Mitral Valve Prolapse	☐Tobacco Habit
☐Cancer	☐Headaches	☐Pacemaker	☐Tonsilitis
☐Chemical Dependency	☐Heart Murmur	☐Radiation Treatment	☐Tuberculosis
☐Chemotherapy	☐Heart Problems	☐Respiratory Disease	☐Ulcer
☐Circulatory Problems	☐Hemophilia	☐Rheumatic Fever	☐Venereal Disease

MEDICATIONS

List medications you are currently taking

_____

_____

ALLERGIES

_____

_____

Date:_____ Signature:_____

Primary Insurance

Patient Name:_____
Last Name First Name Middle Initial

Person Responsible For Account:_____
Last Name First Name Middle Initial

Relation to Patient:_____ Birthdate:_____ Social Security #:_____

Address:_____ Phone:(_____)_____

City:_____ State:_____ Zip:_____

Person Responsible Employed By:_____ Occupation:_____

Business Address:_____ Business Phone:(_____)_____

Insurance Company:_____

Contract #:_____ Group #:_____ Subscriber #:_____

Additional Insurance

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name:_____ Birthdate:_____ Relation to patient:_____

Address (if different than patient's):_____ Phone:(_____)_____

City:_____ State:_____ Zip:_____

Subscriber Employed By:_____ Business Phone:(_____)_____

Insurance Company:_____ Soc. Sec. #:_____

Contract #:_____ Group #:_____ Subscriber #:_____

Names of other dependents covered under this plan:_____

Authorization

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign
Name of Insurance Company(ies)

directly to Dr. Thomas P. Maloney all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature of all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient