Welcome

Thank you for choosing **MST Dental**. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask we would be happy to help.

PATIENT INFORMATION

PLEASE PRINT

Name ______________________________ | ____________________
First Middle Last Preferred Name

Address ______________________ | ____________ | ______ | ________
Street City State Zip

Social Security # ______________ **Birth Date** ______________ **Age** ________

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Home #______________ Cell #______________ Work #______________

May we contact you via e-mail? ☐ Yes ☐ No E-mail address: ______________________

Employer/School ______________________ **Occupation** ______________

Emergency Contact Information:

______________________ | ____________ | ______________________
Name Relation to Patient Home # Work # Cell#

Closest relative not living with you ______________________________
Name and Phone Number

INSURANCE INFORMATION

Primary Dental Carrier:

______________________ | ______________ | ____________
Subscriber/Insured Name Social Security Number Date of Birth

______________________ | ____________ | ______ | ________
Home address-if different than patient-Street City State Zip

__________ | __________ | ______________ | ______________
Home phone Cell phone E-mail address Relationship to Patient

______________________ | ______________ | ____________
Employer Name Occupation Employer Phone #

______________________ | ______________ | ____________
Insurance Company Name Number Contract Number Group

PLEASE CONTINUE ON OTHER SIDE

Secondary Dental Carrier:

Subscriber/Insured Name | Social Security Number | Date of Birth

Home address-if different than patient-Street | City | State | Zip

Home phone | Cell phone | E-mail address | Relationship to Patient

Employer Name | Occupation | Employer Phone #

Insurance Company Name | Contract Number | Group Number

RESPONSIBLE PARTY

Fill out the information below if the patient is a minor (under 18).

Name of Responsible Party | Social Security Number | Date of Birth

Home address-if different than patient-Street | City | State | Zip

Home phone | Cell phone | E-mail address | Relationship to Patient

Employer Name | Occupation | Employer Phone #

Referred By ______________________________

____

Are any other members of your household patients here? (List names and relationship above)

Consent: I herby consent to treatment to be performed by the doctors of MST Dental, P.C. and their associates. Furthermore, I understand the possible complications that might occur from a proposed treatment and that a perfect result cannot be guaranteed.

Agreement to Pay: The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees, and court costs if such be necessary.

The information on this page is true to the best of my knowledge.

Signature of patient (or parent/guardian/personal representative) | **Date**

Print Name: ______________________________

MEDICAL HEALTH HISTORY

Patient Name ______________________________ DOB ____________________

Physician____________________ Office Phone ______________ Date of Last Exam____________

Are you now or have you recently been under a physician's care? ☐ Yes ☐ No

Explain ____

Have you had surgeries or hospitalization in the past 5 years? ☐ Yes ☐ No

Explain ____

Allergies

Yes	No	
☐	☐	Aspirin
☐	☐	Barbiturates
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Sulfa
☐	☐	Tetracycline
☐	☐	Other

____

____

If Female please answer:

Yes	No	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If yes, # of weeks ______
☐	☐	Are you nursing?

Do you smoke or use Tobacco? ☐ Yes ☐ No

Do you use alcohol? ☐ Yes ☐ No

How much do you typically drink in a week? __________

Do you use controlled substances (drugs)? ☐ Yes ☐ No

Medications: List all medications you are taking including over the counter, vitamins, natural or herbal preparations and/or diet supplements.

Check any of the following that you have had or suspected:

Yes	No	Conditions	Yes	No	Conditions	Yes	No	Conditions	Yes	No	Conditions
☐	☐	Abnormal Bleeding	☐	☐	Cosmetic Surgery	☐	☐	Hemophilia	☐	☐	Rheumatic Fever
☐	☐	Alcohol Abuse	☐	☐	Diabetes	☐	☐	Hepatitis A	☐	☐	Seizures
☐	☐	Allergies	☐	☐	Difficulty Breathing	☐	☐	Hepatitis B	☐	☐	Shingles
☐	☐	Anemia	☐	☐	Drug Abuse	☐	☐	High Blood Pressure	☐	☐	Sickle Cell Disease
☐	☐	Angina Pectoris	☐	☐	Emphysema	☐	☐	HIV + AIDS	☐	☐	Sinus Problems
☐	☐	Arthritis	☐	☐	Epilepsy	☐	☐	Kidney Problems	☐	☐	Stroke
☐	☐	Artificial Bones	☐	☐	Fainting Spells	☐	☐	Liver Disease	☐	☐	Thyroid Problems
☐	☐	Artificial Heart Valve	☐	☐	Fever Blisters	☐	☐	Low Blood Pressure	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Frequent Headache	☐	☐	Mitral Valve Prolapse	☐	☐	Ulcers
☐	☐	Blood Transfusion	☐	☐	Glaucoma	☐	☐	Pace Maker	☐	☐	Venereal Disease
☐	☐	Cancer-Chemotherapy	☐	☐	Hay Fever	☐	☐	Pneumocystitis	☐	☐	Yellow Jaundice
☐	☐	colitis	☐	☐	Heart Attack	☐	☐	Psychiatric Problems	☐	☐	
☐	☐	Congenital Heart Defect	☐	☐	Heart Surgery	☐	☐	Radiation Therapy	☐	☐	

Other Conditions: Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes please describe below……

The above information is true to the best of my knowledge.

Signature of Patient or Guardian: ________________________________ **Date:** ______________