



JAMES M. McLAUGHLIN, DDS
JOSEPH M. MIRANDA, DDS

4514 TRAVIS STREET, SUITE 117, DALLAS, TX 75205
TELEPHONE (214) 522-4330

Patient Information

Date _____

Patient's Name _____
LAST FIRST MIDDLE

How do you wish to be addressed? _____ Marital Status _____

Address _____
STREET CITY STATE ZIP

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Birthdate _____ SS# _____

Employer _____ Occupation _____ # Years Employed _____

If patient is a minor, give parent's or guardian's name _____

Has a friend or family member ever been to our office? Yes _____ No _____ Their Name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____ Marital Status _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
STREET CITY STATE ZIP

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ # Years Employed _____

Spouse's Name _____
LAST FIRST MIDDLE

Spouse's Employer _____ Occupation _____ Work Phone _____

Signature

1. I authorize the release of information to all my insurance carriers.
2. I authorize payment directly to my doctor.
3. I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
4. I understand that I am responsible for my bill.

Name: _____

Signature: _____ Date: _____

(Please continue on other side.)

Medical History

1. Are you in good health?..... Yes No
2. Has there been a change in your general health within the past year?..... Yes No
3. Are you under the care of a physician?..... Yes No

4. If so, what condition is being treated?_____

5. Date of your last visit to your physician_____ Nature of visit_____

6. Your physician's name_____ Phone # _____
Address_____

7. Have you been hospitalized or had a serious operation or illness within the last five years?..... Yes No
If so, for what?_____

8. Do you have, or have you had, any of the following diseases or problems? **Please check:**

- | | | | |
|---------------------|--------------------------------------|--------------------|--------------------------------------|
| Heart Failure | Kidney Trouble | Sinus Trouble | Nervousness/Anxiety |
| Emphysema | AIDS/HIV | Rheumatism | Chemotherapy (e.g. Cancer, Leukemia) |
| Diabetes | Ulcers | Allergies or Hives | Radiation Treatment |
| Lupus | Cold Sores | Cortisone Medicine | Heart Disease or Attack |
| Thyroid Disease | Bruise Easily | Scarlet Fever | Mitral Valve Prolapse |
| Angina Pectoris | STD or VD (e.g. Syphilis, Gonorrhea) | Artificial Joint | Psychiatric Treatment |
| Tuberculosis (TB) | Hepatitis A, B, or C | Glaucoma | Fainting or Dizzy Spells |
| High Blood Pressure | Sickle Cell Disease | Anemia | Artificial Heart Valve |
| Asthma | Blood Transfusion | Pain in Jaw Joints | Epilepsy or Seizures |
| Heart Murmur | Liver Disease | Heart Pacemaker | Bleeding Disorder |
| Hay Fever | Yellow Jaundice | Stroke | Rheumatic Fever |
| Arthritis | | Heart Surgery | |

9. Are you taking any drugs or medicine?..... Yes No
If so, what?_____

10. Are you allergic, or have you reacted adversely, to any drugs or medicine?..... Yes No
If so, which drugs? _____

- | | | | | |
|-------------------------------------|--|---|---|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Epinephrine |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Novacaine or Xylocaine | <input type="checkbox"/> Latex | |

11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest?.... Yes No

12. Do your ankles swell during the day?..... Yes No

13. Do you have a disease, condition, or problem not listed above that you think I should know?..... Yes No
If yes, please explain _____

14. **For women only:** Are you pregnant? Yes No
If so, what month?_____ Are you taking birth control pills?..... Yes No

CONSENT: The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient)_____ and further authorize and consent that Doctor choose and employ such assistance as he sees fit. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due an payable at the time services are rendered. I further understand that a 1.5% finance charge (18%) annually will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney's fees as may be required to effect collection of this note.

Patient_____ Date_____ Witness_____

This comprehensive medical/dental history responds to contemporary advances in physical evaluation and to increasing malpractice claims.

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|---------------|------------|---------------|------------|
| Patient _____ | Date _____ | Patient _____ | Date _____ |
| Patient _____ | Date _____ | Patient _____ | Date _____ |
| Patient _____ | Date _____ | Patient _____ | Date _____ |