Michael Moossy, D.D.S.
4200 N. Lamar, Suite 145
Austin, TX 78756
(512) 459-5437

Moossy
GENERAL & COSMETIC DENTISTRY

We are pleased to welcome you to our practice.

In order for us to serve you better, please take a few moments to fill out this form as thoroughly as possible.

(PLEASE PRINT) NAME (Last, First) _____ PREFERED NAME_____

BIRTHDATE ___/___/_____ PRIMARY PHONE # (best to contact you) (_____) _____

CELL # (_____) _____

ADDRESS _____

CITY _____STATE _____ZIP _____

SOCIALSECURITY #_____- _____-_____

SEX: **M F** STATUS: (Circle One) **SINGLE MARRIED DIVORCED WIDOW**

EMAIL _____

EMPLOYER_____OCCUPATION_____

WORK PHONE (IF YOU WANT TO BE CONTACTED AT THIS #) _____ext_____

EMERGENCY CONTACT_____ RELATION _____PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

DENTAL INSURANCE INFORMATION

INSURANCE COMPANY _____ INS SUBSCRIBER ID_____ INSURED'S BIRTHDATE ____/_____/____ INSURED'S SOCIAL SECURITY #_____

GROUP # _____ Insurance Company Phone #_____

PRIMARY ON ACCOUNT (IF YOU ARE NOT THE PRIMARY)

PERSON RESPONSIBLE FOR THIS ACCOUNT_____RELATION_____

ADDRESS _____

CITY _____STATE _____ ZIP _____HOME PHONE _____

EMPLOYER _____WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ **Y** ☐ **N**

PATIENT MEDICAL HISTORY

Are you currently under physician care? ☐ Y ☐ N **If Yes, describe** _____

Have you ever had a blood transfusion? ☐ Y ☐ N **If Yes, give approximate dates**_____

Physicians Name_____ Date of Last Physical Exam _____

4. Are you currently taking any prescribed drugs or substances at this time? (If yes, please list below)

_____

5. Are you taking any over-the-counter medications? If yes,

please list_____

6. Are you taking any vitamins/supplements? If yes, please list_____

7. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?

If yes, please list, If No, put NONE _____

Please CIRCLE "Yes" or "No" whether you have had any of the following:

Acid Reflux Y N
AIDS/HIV positive Y N
Anaphylaxis Y N
Anemia Y N
Artificial heart valve Y N
Is Premed Required? Y N
Arthritis, Rheumatism Y N
Artificial Joins Y N
Is Premed Required? Y N
Asthma Y N
Allergies or hives Y N
Back problems Y N
Blood disease Y N
Cancer Y N
Type/When Treated?_____
_____
Chemotherapy Y N
Circulatory problems Y N
Chronic cough Y N
Cortisone treatments Y N
Diabetes Y N
Epilepsy or seizures Y N
Fainting or dizzy spells Y N
Food Allergies Y N
Glaucoma Y N
Headaches (consistent) Y N
Heart murmur Y N
Is Premed Required? Y N
Heart problems Y N
Explain_____
Heart pacemaker/Surgery Y N
Hemophilia/ Y N
Abnormal Bleeding
Hepatitis: Y N
Type_____
Herpes Y N
High blood pressure Y N
Jaw Pain Y N
Kidney Problems Y N
Liver disease Y N
Material allergies Y N
(latex, wool metal, chemicals)
Mitral valve prolapse Y N
Is Premed Required? Y N
Nervous Problems Y N
Psychiatric treatment Y N
Radiation therapy Y N
Respiratory disease Y N
Shortness of Breath Y N
Shingles Y N
Sleep Apnea Y N
STDs Y N
Stroke Y N
Surgical Implant Y N
Explain_____
Swelling Ankles Y N
Thyroid problems Y N
Tobacco habit Y N
Tonsillitis Y N
Tuberculosis Y N
Ulcers Y N

Do you have or have you had any disease, condition, or problem not listed above? ☐ Y ☐ N

If yes, please list_____

FOR WOMEN ONLY:

Are you pregnant? ☐ Y ☐ N **If yes, what month**? _____ Are you nursing? ☐ Y ☐ N

Are you taking birth control pills? ☐ Y ☐ N

AUTHORIZATIONS: **PLEASE READ, SIGN, AND DATE**

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge I have reviewed the information of this questionnaire. I understand that this information will be used by the dentist to help determine appropriate treatment. If there is any change in my medical status I will inform my dentist.
I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

X_____SIGNATURE OF PATIENT OR PARENT IF MINOR

Today's Date_____