

Patient Information Form

Home Phone _____ Cell Phone _____

Patient Name _____
Last First Middle Preferred Name

Address _____ City _____ State _____ Zip _____

E-Mail Address _____ Gender M F Age _____ Birth date _____

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

Single Married Divorced Social Security # _____ Occupation _____

Employed by _____ Business Phone _____

Business Address _____ City _____ State _____ Zip _____

In case of emergency, who should be notified? Name _____ Phone _____

Dental Insurance Information:

Do you have dental insurance? Yes No Is it through your employer or your spouse's? Mine Spouse

Insurance Company _____ Group # _____

Claims Address _____ City _____ State _____ Zip _____

If Spouse's insurance, please complete the following:

Spouse's Name _____ Birth date _____

Social Security # _____ Employer _____

Employer Address _____ Wk Phone # _____

Notice of Privacy Practices

I have been offered a copy of Hamilton Lakes Dentistry's Privacy Practices.

Please print name Signature Date

I consent to any dental procedures and anesthetics for the treatment of the above named patient. I also understand and agree that I am directly responsible for full payment of treatment at Hamilton Lakes Dentistry, regardless of my dental insurance coverage.

Please print name Signature Date

Dental History

Do you have any present dental complaints? _____

When were your last X-rays taken? _____ When was your last cleaning? _____

	Yes	No		Yes	No
Are you apprehensive about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Does your jaw make noise so that it bothers you or others?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had problems with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your jaws frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Do you gag easily?	<input type="checkbox"/>	<input type="checkbox"/>	Do your jaws ever feel tired?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>	Does your jaw get stuck so that you can't open freely?	<input type="checkbox"/>	<input type="checkbox"/>
Does your food catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Does it hurt when you chew or open wide to take a bite?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty in chewing your food?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or pain in front of the ears?	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew on only one side of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any jaw symptoms or headaches upon awaking in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid brushing any part of your mouth because of pain?	<input type="checkbox"/>	<input type="checkbox"/>	Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums feel swollen or tender?	<input type="checkbox"/>	<input type="checkbox"/>	Do you find jaw pain or discomfort extremely frustrating or depressing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever noticed slow-healing sores in or about your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have temporomandibular (jaw) disorder (TMD)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel twinges of pain when your teeth come in contact with:			Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	<input type="checkbox"/>	<input type="checkbox"/>
Hot foods or liquids?	<input type="checkbox"/>	<input type="checkbox"/>	Are you aware of an uncomfortable bite?	<input type="checkbox"/>	<input type="checkbox"/>
Cold foods or liquids?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a blow to the jaw (trauma)?	<input type="checkbox"/>	<input type="checkbox"/>
Sours?	<input type="checkbox"/>	<input type="checkbox"/>	Are you a habitual gum chewer or pipe smoker?	<input type="checkbox"/>	<input type="checkbox"/>
Sweets?	<input type="checkbox"/>	<input type="checkbox"/>	Are you unable to open your mouth as far as you want?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take fluoride supplements?	<input type="checkbox"/>	<input type="checkbox"/>	Are you dissatisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>

Medical History

Physician _____ Phone _____

Do you have an existing illness? _____ If yes, explain _____

Have you been hospitalized in the past two years? _____ If yes, explain _____

Do you bleed excessively when cut? _____ Do you smoke? _____ If yes, how much? _____

Are you taking any medications? Yes No Drug _____ Dosage _____

Have you ever or are you currently taking meds for bone loss or osteoporosis? If yes, please list _____

Please check yes or no if you have, or have had any of the following:

	Yes	No		Yes	No
1. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	16. Allergy to Latex	<input type="checkbox"/>	<input type="checkbox"/>
2. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	17. Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
3. Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	18. Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
4. Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	19. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
5. Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	20. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
6. Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	21. Allergy to (a) Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
7. Joint/Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>	22. (b) Other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
8. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	23. (c) Local Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>
9. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	24. (d) Other	<input type="checkbox"/>	<input type="checkbox"/>
10. Tumor History	<input type="checkbox"/>	<input type="checkbox"/>	25. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
11. STD	<input type="checkbox"/>	<input type="checkbox"/>	26. AIDS (HIV)	<input type="checkbox"/>	<input type="checkbox"/>
12. Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	27. Are you in a high risk group for HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>
13. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	28. Do you take any supplemental medication (herbs or vitamins)?	<input type="checkbox"/>	<input type="checkbox"/>
14. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Please List _____		
15. Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>			