

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 Widowed 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 _____ ID # _____ 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 understand that my insurance is an agreement between me and my insurance company. I also understand that I am responsible for my balance regardless of my insurance coverage. Lastly, I understand that I may be charged a 1.5% per month or 18% per year finance charge if my balance goes beyond 90 days.

Please print name

Signature

Date

Dental History

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"/>

Please tell us about any dental concerns you may have

Any dental conditions or treatments you would like more information on?

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 _____

Have you been told you need to premedicate for dental appointments? _____ If yes, which medication? _____

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"/>	24. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
2. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	25. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
3. Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	26. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
4. Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	27. Allergy to (a) Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
5. Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	28. (b) Other Antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	29. (c) Local Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>
7. Joint/Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>	30. (d) Other _____	<input type="checkbox"/>	<input type="checkbox"/>
8. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	31. HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
9. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	32. Are you in a high risk?	<input type="checkbox"/>	<input type="checkbox"/>
10. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	group for HIV infection?		
11. Tumor History	<input type="checkbox"/>	<input type="checkbox"/>	33. Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
12. STD	<input type="checkbox"/>	<input type="checkbox"/>	34. Do you snore?	<input type="checkbox"/>	<input type="checkbox"/>
- If yes, please list _____			35. Currently use CPAP	<input type="checkbox"/>	<input type="checkbox"/>
13. Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	36. Previously used CPAP	<input type="checkbox"/>	<input type="checkbox"/>
14. Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	37. Had a sleep study?	<input type="checkbox"/>	<input type="checkbox"/>
15. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what year? _____		
16. Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	38. Experience excessive daytime	<input type="checkbox"/>	<input type="checkbox"/>
17. GERD/ Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	sleepiness		
18. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	39. Do you take any supplemental	<input type="checkbox"/>	<input type="checkbox"/>
19. Allergy to Latex	<input type="checkbox"/>	<input type="checkbox"/>	medications? (herbs or vitamins)		
20. Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Please list _____		
21. Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____		

FOR OFFICE USE ONLY

Changes: _____ Sign & Date _____

Changes: _____ Sign & Date _____

Changes: _____ Sign & Date _____

Changes: _____ Sign & Date _____

Changes: _____ Sign & Date _____