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_____ID #_____Group #_____

Claims Address_____ City_____ State_____ Zip_____

Insurance phone _____

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

Patient Name _____

Dental History

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

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

Please tell us about any dental concerns you may have

_____

_____

_____

_____

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

_____

_____

_____

_____

Patient Name _____

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	□	□	24. Tuberculosis	□	□
2. High Blood Pressure	□	□	25. Asthma	□	□
3. Blood Disease	□	□	26. Are you pregnant?	□	□
4. Rheumatic Fever	□	□	27. Allergy to (a) Penicillin	□	□
5. Heart Murmur	□	□	28. (b) Other Antibiotics_____	□	□
6. Mitral Valve Prolapse	□	□	29. (c) Local Anesthetics	□	□
7. Joint/Valve Replacement	□	□	30. (d) Other_____	□	□
8. Epilepsy	□	□	31. HIV/AIDS	□	□
9. Arthritis	□	□	32. Are you in a high risk?	□	□
10. Cancer	□	□	group for HIV infection?		
11. Tumor History	□	□	33. Sleep Apnea	□	□
12. STD	□	□	34. Do you snore?	□	□
- If yes, please list _____			35. Currently use CPAP	□	□
13. Radiation Treatment	□	□	36. Previously used CPAP	□	□
14. Chemotherapy	□	□	37. Had a sleep study?	□	□
15. Diabetes	□	□	If yes, what year?_____		
-If yes, what is your HBA1C level? _____			38. Experience excessive daytime	□	□
16. Liver Disease	□	□	sleepiness?		
17. GERD/ Acid Reflux	□	□	39. Botox use?	□	□
18. Stroke	□	□	39. Do you take any supplemental	□	□
19. Allergy to Latex	□	□	medications? (herbs or vitamins)		
20. Kidney Disease	□	□	Please list_____		
21. Hepatitis	□	□	_____		

FOR OFFICE USE ONLY

Changes: _____ Sign & Date _____

Changes: _____ Sign & Date _____

Hamilton Lakes Dentistry

Policies

The team at Hamilton Lakes Dentistry pledges to deliver you quality, courteous care in a clean and comfortable atmosphere. Our team will offer efficient and experienced service, always listening to you and being respectful of the time you spend with us. We promise that we will always provide you with exceptional dental care. We are your home for professional dental excellence.

Appointments

It is necessary that we work by appointments. Unfortunately, emergencies do occur that occasionally cause delays in our schedule. However, we will try our best to honor your appointment time. Please remember that the time we have reserved for you is exclusively for you. Any changes in your schedule will affect our schedule as well. We do require ***2 business days'*** notice for any appointment changes. We reserve the right to charge the credit card we have on file for your account in the event that 2 or more appointments are cancelled/rescheduled without the proper 2 business days' notice.

Financial

In the interest of better understanding, we believe financial arrangements must be completely understood and agreed upon before treatment has begun. Your treatment will be explained to you, and you will be given an estimate of the fees.

Your dental treatment fees can be handled in one of the following ways: You may pay cash, check, or credit card (Visa, MasterCard, American Express and Discover). ***We do expect payment for services as they are rendered.*** If you feel you will not be able to pay the balance due on the day the service is rendered, you will need to discuss the advantages of using CareCredit, which will offer you small minimum monthly payments. Please feel free to discuss any of the above payment options with our Patient Care Coordinators. Insurance deductibles, co-pays, and fees or portions of fees not covered by dental insurance are also due at the time of service and are payable in the same fashion as stated above. Balances that remain on an account for 60 days will be charged a finance fee of 1.5% of the balance.

Dental Benefits

Congratulations on having dental insurance! As a convenience for you, our office will submit charges for services to your insurance carrier, ***but we consider the patient responsible for the account.*** In other words, the services provided by any dentist amounts to an agreement between the patient and this office. The insurance relationship constitutes an agreement between the carrier and the patient.

It will be helpful to us for you to bring any information regarding your insurance plan with you to keep in your patient record for reference. This will enable our business office team to better assist you in ***estimating*** the percentages payable by your insurance plan. If you forget to bring your insurance information, please send us a copy within the next two days of your appointment. (If you do not bring your insurance information with you, you will be expected to pay for the services at the time they are rendered.) If there is a question about your account or your insurance, please call. Many times, a phone call will prevent any misunderstanding.

If your insurance company has not paid within 45 days of the date the claim was filed, the full amount of the claim will be your responsibility. It will then be your responsibility to contact your insurance carrier concerning the outstanding claims. We will be happy to receive your call concerning questions about your insurance, and we can tell you which claims have been received, for what amount, which claims are outstanding, and when the claims were sent. You should then take any questions to the insurance carrier.

Should you have any questions about our practice policies, please feel free to discuss them with our business office team. We thank you for the confidence you have placed in us. We are complimented that you have chosen us. You may rest assured that we will do everything in our power to make your visits to our office as pleasant as possible.

_____ _____

Patient Signature (Parent's Signature if patient is a minor) Date