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____________

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
Are you apprehensive about dental treatment?		
Have you had problems with previous dental treatment?		
Do you gag easily?		
Do you wear dentures?		
Does your food catch between your teeth?		
Do you have difficulty in chewing your food?		
Do you chew on only one side of your mouth?		
Do you avoid brushing any part of your mouth because of pain?		
Do your gums feel swollen or tender?		
Have you ever noticed slow-healing sores in or about your mouth?		
Are your teeth sensitive?		
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?		
Cold foods or liquids?		
Sours?		
Sweets?		
Do you take fluoride supplements?		

	Yes	No
Does your jaw make noise so that it bothers you or others?		
Do you clench or grind your jaws frequently?		
Do your jaws ever feel tired?		
Does your jaw get stuck so that you can't open freely?		
Does it hurt when you chew or open wide to take a bite?		
Do you have earaches or pain in front of the ears?		
Do you have any jaw symptoms or headaches upon awaking in the morning?		
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?		
Do you find jaw pain or discomfort extremely frustrating or depressing?		
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?		
Do you have temporomandibular (jaw) disorder (TMD)?		
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?		
Are you aware of an uncomfortable bite?		
Have you had a blow to the jaw (trauma)?		
Are you a habitual gum chewer or pipe smoker?		
Are you unable to open your mouth as far as you want?		
Are you dissatisfied with the appearance of your teeth?		

Please tell us about any dental concerns you may have

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

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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____

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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
1. Heart Disease		
2. High Blood Pressure		
3. Blood Disease		
4. Rheumatic Fever		
5. Heart Murmur		
6. Mitral Valve Prolapse		
7. Joint/Valve Replacement		
8. Epilepsy		
9. Arthritis		
10. Cancer		
11. Tumor History		
12. STD - If yes, please list ____________________		
13. Radiation Treatment		
14. Chemotherapy		
15. Diabetes		
16. Liver Disease		
17. GERD/ Acid Reflux		
18. Stroke		
19. Allergy to Latex		
20. Kidney Disease		
21. Hepatitis		

	Yes	No
24. Tuberculosis		
25. Asthma		
26. Are you pregnant?		
27. Allergy to (a) Penicillin		
28. (b) Other Antibiotics____________		
29. (c) Local Anesthetics		
30. (d) Other_____________________		
31. HIV/AIDS		
32. Are you in a high risk? group for HIV infection?		
33. Sleep Apnea		
34. Do you snore?		
35. Currently use CPAP		
36. Previously used CPAP		
37. Had a sleep study? If yes, what year?_______________		
38. Experience excessive daytime sleepiness		
39. Do you take any supplemental medications? (herbs or vitamins) Please list______________________ ______________________________		

FOR OFFICE USE ONLY

Changes: ____ Sign & Date____________________________________

Changes: ____ Sign & Date ____________________________________

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Changes: ____ Sign & Date ____________________________________