PATIENT INFORMATION

Patient Name: ____ Date of Birth: _____________
First MI Last

Preferred Name: ____________________ Social Security #: ________________ O Male O Female

Marital Status: Single Married Divorced Widowed Spouse's Name: _____________________

Address: ____
Street or P.O. Box City State Zip Code

Home # (_____)_____________ Work # (_____)_____________ Cell # (_____)_____________

Email: ____

Preferred Pharmacy: _______________________________ Location: _________________________

RESPONSIBLE BILLING PARTY

Please complete if the responsible billing party is different from the person listed above.

Name: ____ Phone (______)_______________

Address: O Same as above ____
Street or P.O. Box City State Zip Code

Relationship: O Spouse O Parent O Partner O Other (please specify)_____________________

* If you are 18 years of age or older, we will need additional authorization from your responsible party.

PRIMARY INSURANCE INFORMATION

Employer: _______________________________ Insurance Company: ________________________

Policy Holder Name: _____________________________ Relationship to patient: _______________

Policy Holder Social Security #: ________________________ Date of Birth: ____________________

Member ID #: ______________________________ Group #: ________________________________

If you have secondary insurance, please list the information here: ____________________________

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PLEASE SIGN BELOW

I have received, read, and agree to the terms of the office financial and appointment cancellation policies

Authorized Signature ____ Date: _________

In addition to myself, I allow my health information to be discussed with the following people:

____ relationship _________________________________

I have received, read, and agree to the terms of the HIPAA Notice of Privacy Practices

Authorized Signature ____ Date: _________

Hawkeye Family Dental
Patient Medical History

Patient Name: ______________________ Patient Date of Birth: ______________ Date: ________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you are taking, could have an important correlation with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? O Yes O No If yes, please explain: ______________________

Have you been hospitalized or had a major operation? O Yes O No If yes, please explain: ______________________

Have you ever had a serious head or neck injury? O Yes O No If yes, please explain: ______________________

Do you use tobacco? O Yes O No

Have you been told to take a pre-med before treatment? O Yes O No If yes, for what? ______________________

Have you had a joint replaced? O Yes O No If yes, which joint? __________ Date of placement: ______

Have you had any revisions to your joint replacement? O Yes O No If yes, please explain: ______________________

Are you on a special diet? O Yes O No If yes, please explain: ______________________

Please list all of your medications and reason for use below:

Medication	Use	Medication	Use	Medication	Use

Women: Are you:
Pregnant/Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following?
O Aspirin O Penicillin/Amoxicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics O Sulfa O Other
If yes, please describe reaction: ______________________

Do you have, or have you had, any of the following?

AIDS/HIV positive	O Yes	O No	Diabetes	O Yes	O No	Heart trouble continued		
Alzheimer's Disease	O Yes	O No	Drug Addiction	O Yes	O No	Mitral Valve Prolapse	O Yes	O No
Arthritis/Gout	O Yes	O No	Epilepsy or Seizures	O Yes	O No	Stroke	O Yes	O No
Asthma	O Yes	O No	Fainting Spells/Dizziness	O Yes	O No	High Blood Pressure	O Yes	O No
Blood/Bleeding Disorder	O Yes	O No	Hepatitis A, B, or C	O Yes	O No	Hives or Rash	O Yes	O No
Breathing Problem	O Yes	O No	Heart Trouble/Disease	O Yes	O No	Sinus Trouble	O Yes	O No
Cancer	O Yes	O No	Heart Pace Maker	O Yes	O No	Stomach/Intestinal Disease	O Yes	O No
Chemotherapy/Radiation	O Yes	O No	Heart Attack/Failure	O Yes	O No	Thyroid Disease	O Yes	O No
Cold Sores	O Yes	O No	Artificial Heart Valve	O Yes	O No	Tuberculosis	O Yes	O No

Comments: ______________________

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent, or guardian:______________________ Date: ________

Patient Dental History

How long has it been since your last cleaning? ______________________________

Previous Dentist ______________________ Location _________________________

Reason you are seeking treatment ____

How did you hear about our office?

_____ Yellowpages _____Facebook

_____ Sign on building _____Insurance Website

_____ A friend/relative/co-worker Name: _____________________________

May we thank them for referring you? Yes No

_____ Other: ________________________________

Do your gums bleed while brushing or flossing?	Yes	No
Are your teeth sensitive to hot or cold liquids/foods?	Yes	No
Are your teeth sensitive to sweet or sour liquids/foods?	Yes	No
Do you feel pain to any of your teeth?	Yes	No
Do you have any sores or lumps in or near your mouth?	Yes	No
Have you had any head, neck or jaw injuries?	Yes	No

Have you ever experienced any of the following problems in your jaw?

_____ Clicking _____ Pain (joint, ear, side of face)

_____ Difficulty opening or closing _____ Difficulty in chewing

Do you have frequent headaches?	Yes	No
Do you clench or grind your teeth?	Yes	No
Do you snore?	Yes	No
Do you wake up feeling tired?	Yes	No
Do you bite your lips or cheeks frequently?	Yes	No
Have you ever had any difficult extractions in the past?	Yes	No
Have you ever had prolonged bleeding following extractions?	Yes	No
Have you had any orthodontic treatment?	Yes	No
If yes, do you have retainers?	Yes	No
Do you wear dentures or partials?	Yes	No

If yes, date of placement : ______________________________

Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes No

Do you like your smile? Yes No

Is there anything you would like to change about your smile? Yes No

If yes, what would you like to change? ________________________________

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