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: _____

_____

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.

Do you have any medical concerns/conditions that are currently monitored by a physician? 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: _____

Are you currently undergoing cancer treatment? O Yes O No If yes, for what? _____

Have you been told to take a pre-med before treatment? O Yes O No If yes, which joint? _____ Date of placement: _____

Have you had a joint replaced? O Yes O No If yes, please explain: _____

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: _____

Do you use tobacco? O Yes O No

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 No Known Allergies
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: _____

_____

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? _____
_____
_____