Please complete the following confidential information

GETTING TO KNOW YOU 1

Patient _____ Birthdate: _____
Last Name (Mr., Mrs., Miss) *First Name* *Middle Name*

Full name of husband, wife or parent if child: _____

Driver's License No. _____ Social Security No.: _____

Residence Address: _____ Phone: ( ) _____

City: _____ Zip Code: _____

Employer: _____ Occupation: _____

Business Address: _____ Phone: ( ) _____

City: _____ Zip Code: _____

Spouse employed by: _____ Occupation: _____ Social Security No.: _____

City: _____ Zip Code: _____ Phone: ( ) _____

2

Is another member of your family, or relative a patient at our office? _____

Who can we thank for referring you to us: _____

_____

Person to contact for emergency: _____

_____ Phone ( ) _____

Address: _____

3

Primary carrier

Insurance Co.: _____

Employee: _____

Address: _____

Union or Local #: _____

Group#: _____

Date Employed: _____

Secondary carrier

Insurance Co.: _____

Employee: _____

Address: _____

Union or Local #: _____

Group#: _____

Date Employed: _____

MEDICAL HISTORY 4

General health *(please check):* EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

My last physical examination was on: _____

Are you now under the care of a physician? _____

Physician's Name: _____ Phone: ( ) _____

Have you been hospitalized or had a serious illness within the past 5 years . . . YES ☐ NO ☐ Are you now taking any medication drugs / pills? . . . YES ☐ NO ☐

If yes, please list those drugs _____

_____

Are you allergic or have you reacted adversely to any of the following medications: *(Please check if yes)*

☐ Penicillin ☐ Aspirin ☐ Erythromycin ☐ Percodan ☐ Nitrous Oxide ☐ Novacaine or
☐ Codeine ☐ Local Anesthetic ☐ Tetracycline ☐ Valium ☐ Sulfa Drugs ☐ Xylocaine

Are you aware of being allergic to any other medication or substance? YES ☐ NO ☐ List: _____

WOMEN *(Please Check):* ☐ Pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss _____ YES ☐ NO ☐

Have you ever had: *(Please check if yes)* * If yes to any of the starred conditions, please call prior to your appointment . . . Premedication may be required

	Yes		Yes		Yes		Yes		Yes
Heart Trouble/Disease	☐	Bisphosphonate Therapy	☐	Emphysema	☐	Yellow Jaundice *	☐	Cold Sores	☐
Heart Murmur *	☐	Anemia	☐	Tuberculosis	☐	Kidney Problems *	☐	Fever Blisters	☐
Irregular Heart Beat	☐	Excessive Bleeding	☐	Cancer	☐	Renal Dialysis	☐	Herpes	☐
Angina/Chest Pain	☐	Sickle Cell Disease	☐	Treatment (Radiation)	☐	Thyroid Disease	☐	Stroke	☐
Heart Attack/Failure	☐	Hemophilia (Bleeding Problem)	☐	Chemotherapy	☐	Parathyroid Disease	☐	Convulsions	☐
Congenital Heart Disorder	☐	Leukemia	☐	Stomach/Intestinal Disease	☐	Arthritis/Gout	☐	Epilepsy or Seizures	☐
Mitral Valve Prolapse *	☐	Blood Transfusion	☐	Ulcers	☐	Pheumatism	☐	Fainting or Dizziness	☐
Scarlet Fever	☐	Swelling of Limbs	☐	Recent Weight Loss	☐	Pain in Jaw Joints	☐	Glaucoma	☐
Rheumatic Fever *	☐	Lung Disease	☐	Frequent Diarrhea	☐	Cortisone Medicine	☐	Tumor or Growths	☐
Artificial Heart Valve *	☐	Breathing Problem	☐	Diabetes	☐	Artificial Joint *	☐	Nervousness	☐
Heart Pace Maker *	☐	Shortness of Breath	☐	Excessive Thirst	☐	Venereal Disease *	☐	Psychiatric Care	☐
Heart Surgery *	☐	Frequent Cough	☐	Hypoglycemia	☐	AIDS	☐	Alzheimer's Disease	☐
High Blood Pressure	☐	Hay Fever	☐	Liver Disease	☐	HIV Positive	☐	Allergies (Medicines)	☐
Low Blood Pressure	☐	Sinus Trouble	☐	Hepatitis A (Infectious)	☐	Genital Herpes	☐	Allergies (Pollen/Dust)	☐
Blood Disease	☐	Asthma	☐	Hepatitis B or C	☐	Drug Addiction	☐	Hives or Rash	☐

Has anyone in your family had diabetes _____ YES ☐ NO ☐

Have you ever had any other serious illness not checked above? Discuss _____ YES ☐ NO ☐

To the best of my knowledge all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ B/P _____

History Review and Significant Findings: _____

_____

DENTAL HISTORY

5

1. Reason for this visit: _____
2. Previous dentist (optional): _____
   Date of last dental visit: _____
3. Do you visit your dentist and hygienist for:
   _____ Preventative dental care (maintenance of oral health)
   _____ Remedial dental care (only when something breaks)
   _____ Emergency dental care (only when in pain)
4. How often do you brush your teeth? _____
   Do you brush: _____ vigorously _____ lightly
5. How often do you floss? _____ daily _____ occasionally _____ seldom/never
6. Do you feel nervous about dental treatment? ☐ Yes ☐ No
   Is there anything about dental treatment that bothers you? ☐ Yes ☐ No
   If yes, explain _____
7. Have you ever had an upsetting experience during a dental visit?
   If yes, explain _____
8. Have you ever had nitrous oxide (laughing gas) ☐ Yes ☐ No
9. Have you ever had:
   a. Orthodontic treatment? Braces? (Year _____) ☐ Yes ☐ No
   b. Oral surgery? Extractions? (Year _____) ☐ Yes ☐ No
   c. Periodontal treatment? Gum treatment? (Year _____) ☐ Yes ☐ No
   d. Your bite adjusted? (Year _____) ☐ Yes ☐ No
   e. Worn a bite plate or other appliance? (Year _____) ☐ Yes ☐ No
10. Have you noticed any:
    a. Bleeding or swelling of the gums? ☐ Yes ☐ No
    b. Loosening of your teeth? ☐ Yes ☐ No
    c. Food becoming caught between your teeth? ☐ Yes ☐ No
    d. Pain due to heat, cold, or sweets? ☐ Yes ☐ No
       Where _____ How long _____
11. Do you find yourself avoiding a particular area of your mouth when:
    a. Chewing? (Where / Why) _____ ☐ Yes ☐ No
    b. Brushing? (Where / Why) _____ ☐ Yes ☐ No
    c. Flossing? (Where / Why) _____ ☐ Yes ☐ No
12. Have you ever experienced:
    a. Clicking of the jaw ☐ Yes ☐ No
    b. Pain in the joint, ear or side of face ☐ Yes ☐ No
    c. Frequent or severe headaches ☐ Yes ☐ No
       How frequent? _____ Medications
    d. Difficulty opening or closing ☐ Yes ☐ No
    e. Difficulty in chewing ☐ Yes ☐ No
    f. Ringing or buzzing in your ears ☐ Yes ☐ No
    g. A tired feeling in your face while chewing or after considerable talking ☐ Yes ☐ No
13. Do you find yourself
    a. Clenching or grinding your teeth? ☐ Yes ☐ No
       If yes: _____ While awake _____ While asleep
    b. Biting your lips, cheek or tongue regularly ☐ Yes ☐ No
    c. Holding foreign objects with your teeth (pencils, pens) ☐ Yes ☐ No
    d. Biting your fingernails ☐ Yes ☐ No
    e. Breathing through your mouth while awake or asleep ☐ Yes ☐ No
14. Do you smoke or use other forms of tobacco? ☐ Yes ☐ No
    Do you have any sores or growths in your mouth? ☐ Yes ☐ No
    If yes, explain _____
15. Is it important to you to keep your teeth? ☐ Yes ☐ No
16. Are you satisfied with the appearance of your smile? ☐ Yes ☐ No
17. What would you change about your smile? _____
18. What can we do to make your appointments more comfortable relaxing dental experience?
    _____ Provide movie glasses
    _____ Warm me with a blanket when cold
    _____ Keep me from feeling the injections
    _____ Talk to me about my dental treatment at each visit before we begin
    _____ Administer nitrous oxide to lessen the anxiety
    _____ Prescribe sedatives prior to treatment to lessen the anxiety
    _____ Other _____

email

CONSENT FOR TREATMENT

6

The undersigned hereby authorizes Dr. Hale to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Dr. Hale to make a thorough diagnosis of the patients needs I also authorize Dr. Hale to perform any and all forms of treatment, medication & therapy that may be indicated in connection with

(Name of Patient) _____

And further authorize and consent that Dr. Hale choose and employ such assistance as he sees fit. I also understand the use of anestetics agents bodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine. Due and payable at the time of services are rendered unless financial arrangements have been made in the event of default. I promise to pay legal interest indebtedness together with such collection costs and reasonable attorney fees as may be required to affect collection of this nets.

X _____ X _____ _____

PATIENT'S SIGNATURE **PARENT OR RESPONSIBLE** **RELATIONSHIP** **DATE**