WelcomeTo Our Practice

Date ___________________________

Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First name ________________________ M.I. _______Last name _____________ Nickname ________________

Sex: ☐Male ☐Female Birth Date ____________________ Age _________ Soc. Sec.# ______________________ Email ______________

Street ____ City _________________________ State _______ Zip ______________

Home Tel. (______) ________________Cell Tel. (______) _________________ Have you ever been a patient of this practice before? ☐ Yes ☐ No

Dentist _____________________________ Medical Doctor _________________________Referred by _________________________

Driver's Lic # ____________________________ Nearest relative not living with you ____________________ Tel. (______) ___________

Employer _______________________________Bus. Tel. (______) ______________ personal payment type: ☐ Cash ☐ Check ☐ Credit Card

Who will be responsible for your account? (if self, skip to next section) ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other
____

Name ___________________________ S.S.# _____________________Birth Date ______________ Age ______Tel. (______) ________

Street ____ City _______________ State _________ Zip ____________

Employer ____ Bus.Tel. (______) _______________________

Spouse or other guarantor information (if different from above)

Name ___________________________ Relation ______________________S.S.# _____________________ Tel. (______) __________

Street ____ City _________________ State _______ Zip ___________

Employer ____ Bus.Tel. (______) _______________________

Insurance information

Student: ☐ Full time ☐ Part time School Name/Address ____
☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Legally Separated
Employed: ☐ Full time ☐ Part time ☐ Retired ____

Primary Insurance Company

Dental Insurance :

Employer ____

Bus. Address ____

Bus. Tel. (_______) _____________ Plan___________________

Ins. Co. Name _______________________________________

Address ____

_____________________ Tel. (______) ___________________

Group # ____________________ Group name _______________

Insured Party _____________________ Relation _____________

Sex: ☐Male ☐Female Birth Date ____________________________

Street ____

City, State, Zip ______________________________________

Tel. (______) ___________________ S.S.# _________________

I.D. # ____

Secondary Insurance Company

Dental Insurance :

Employer ____

Bus. Address ____

Bus. Tel. (_______) _________________ Plan _________________

Ins. Co. Name _______________________________________

Address ____

_________________________ Tel. (______) ________________

Group # _______________ Group name _____________________

Insured Party ___________________ Relation _________________

Sex: ☐Male ☐Female Birth Date ____________________________

Street ____

City, State, Zip ______________________________________

Tel. (______) ______________ S.S.# _______________________

I.D. # ____

Dental Information

Reason for today's visit: ☐ Exam ☐ Consultation ☐ Emergency Are you in pain? ☐ Yes ☐ N For how long? ______________________

Please indicate any of the following problems by checking off the corresponding box:

☐ Discomfort, clicking, or popping in jaw
☐ Red, swollen or bleeding gums
☐ A removable dental appliance
☐ Blisters/Sores in or around the mouth
☐ Recent infections or sore throat
☐ Lost/broken filling(s)
☐ Teeth grinding/clenching
☐ Ringing in ears
☐ Broken/chipped tooth
☐ Toothache
☐ Stained teeth
☐ Locking jaw
☐ Bad breath
☐ Burning tongue/lips
☐ Loose/shifting teeth
☐ Prolonged bleeding from injury or extraction
☐ Food catches between teeth
☐ Swelling/lumps in mouth
☐ Other ________________________

My teeth are sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Biting

Last Dental exam _____________________ **Last Dental X-rays** __________ Times a day you brush? ______Times a week you floss __________

What type of tooth bristles do you use? ☐ Soft ☐ Medium ☐ Hard How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

Do you smoke? ☐ Yes ☐ No Do you use chewing tobacco? ☐ Yes ☐ No

Medical History

Are you in good health? ☐ Yes ☐ No Height: ______________________ Weight: _________________________

Are you under the care of a physician? ☐ Yes ☐ No Have you had any illness, operation or been hospitalized in the past five years? ☐ Yes ☐ No

Do you have, or have you had any of the following diseases, medical conditions, or procedures?

☐ Rheumatic/Scarlet Fever
☐ Mitral valve prolapse
☐ Heart murmur
☐ High/Low blood pressure
☐ Congenital heart disorder
☐ Chest pain/Angina
☐ Heart attack(s)/Failure
☐ Irregular heart beat

- ☐ Cardiac pacemaker
- ☐ Heart surgery/disease
- ☐ Bronchitis/Chronic cough
- ☐ Mental health problems
- ☐ Damaged heart valves
- ☐ Pulmonary Shunt
- ☐ Asthma
- ☐ Hay fever/Sinus problems
- ☐ Snoring/Sleep apnea
- ☐ Respiratory problems
- ☐ Tuberculosis
- ☐ Emphysema/Lung disease
- ☐ Cancer/Leukemia
- ☐ Artificial heart valve
- ☐ Blood transfusion
- ☐ Blood disorder
- ☐ Bruise easily
- ☐ A history of drug abuse
- ☐ Eye disease/Glaucoma
- ☐ Abnormal bleeding
- ☐ Bacterial endocarditis
- ☐ Jaundice/Liver disease
- ☐ Hepatitis A, B or C
- ☐ HIV/AIDS
- ☐ Infectious mononucleosis
- ☐ Fainting spells
- ☐ Convulsions/Epilepsy
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Diabetes/Hypoglycemia
- ☐ A history of alcohol abuse
- ☐ Sexually transmitted diseases
- ☐ Alzheimer's disease
- ☐ Kidney problems
- ☐ Are you on dialysis?
- ☐ Arthritis
- ☐ Stomach ulcers/Intestinal disease
- ☐ Anemia
- ☐ Tumor or growth
- ☐ Artificial Joint(s)
- ☐ Nervousness
- ☐ Other

____

Medications

Are you now taking:

- ☐ **Blood Thinners** - (Coumadin, Aspirin, etc.)
- ☐ Tranquilizers
- ☐ Muscle relaxers
- ☐ Insulin
- ☐ Stimulants
- ☐ Antidepressants
- ☐ Have you ever taken Fen-Phen?
- ☐ Cortisone Medicine
- ☐ **Bisphosphonates –** (Fosamax, Actonel, Boniva, etc.)

Do you need pre-medication? ☐ Yes ☐ No

Please list any other medications you are taking (including natural, herbal, or homeopathic products): ____

____

Are you allergic to or had a reaction to:

- ☐ Penicillin/ Amoxicillin
- ☐ Valium or other tranquilizers
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Local anesthetic (numbing meds)
- ☐ Codeine or other narcotics
- ☐ Latex
- ☐ Food allergies ______________

Please list any other medications you are allergic to: ____

Please list any other allergies you have, other than drug allergies: ____

Q: 1) - 4) below for women only:

(Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your Physician/Gynecologist for assistance regarding additional methods of birth control.)

1). Is there a possibility of pregnancy? ☐ Yes ☐ No 2). Expected delivery date: ______________________________

3). Are you nursing? ☐ Yes ☐ No 4). Are you taking birth control pills? ☐ Yes ☐ No

1. ***I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Hamel, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.***

Signature of patient (Parent or Guardian if minor): ________________________________ **Date**: ______________ **Reviewed by**: __________

2. ***This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to Dr. John Hamel of the benefits otherwise payable to me.***

Signature of patient (Parent or Guardian if minor): ____ **Date**: ______________________________

3. ***I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.***

Signature of patient (Parent or Guardian if minor): ____ **Date**: ______________________________