

Patient's Name: _____ How do you prefer to be addressed? _____ Sex (Circle One): Male Female
 Birth Date: ____ / ____ / ____ Age: _____ Marital Status (Circle One): Single Married Widowed Separated Divorced
 SS#: _____ Mailing Address: _____ City: _____ State: ____ Zip: _____
 E-mail: _____ Home Phone: (____) _____ Cell: (____) _____
 Dental Insurance Carrier: _____ Policy Holder: _____ Policy Holder DOB: _____
 Insurance ID Number: _____ Work Phone: (____) _____
 Occupation: _____ Employer: _____
 If Student, Name of School/College: PT FT _____ City: _____ State: ____ Zip: _____
 Who can we thank for referring you to our office? _____

If the person responsible for payment is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip.

Name of Responsible Party: _____ Relationship to Patient: _____
 Mailing Address: _____ City: _____ State: ____ Zip: _____
 E-mail: _____ Home Phone: (____) _____ Cell: (____) _____
 Work Phone: (____) _____ Occupation: _____ Employer: _____

Medical History

Date of last complete physical: _____ Medical Doctor's Name: _____ Doctor's Phone #:(____) _____
 Are you taking any medication, vitamins, or supplements? Yes / No Please list: _____
 Are you pregnant? Yes _____ No _____ If yes, how many months? _____
 Are you allergic to: (Select all that apply) Penicillin Codeine Local injected anesthetic Latex Other: _____
 Please describe any current treatment, impending operation, or any other medical or dental condition that you have.

Have you been told that you need to take antibiotics prior to dental cleanings or other treatment? Yes ___ No ___

Medication & Reason: _____

Do you have or have you ever had any of the following? Check all that apply:

- | | | | | |
|---|--|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Excessive urination | <input type="checkbox"/> Implants | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Clicking or popping in jaw |
| <input type="checkbox"/> Radiation treatments | <input type="checkbox"/> Anemia | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Malignancies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> AIDS, HIV positive | <input type="checkbox"/> Narrow Angle Glaucoma | <input type="checkbox"/> Sensitivity to hot and cold |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Prolonged bleeding | <input type="checkbox"/> Sensitivity to epinephrine | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Psychiatric care or nervous problems | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Food catching between teeth |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Herpes | <input type="checkbox"/> High or low blood pressure (circle one) | <input type="checkbox"/> Bad breath or sour taste | <input type="checkbox"/> Pain/soreness (circle one) ears, eyes, face |
| <input type="checkbox"/> A heart condition | <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Burning sensations in mouth | <input type="checkbox"/> Headaches/migraines, |
| <input type="checkbox"/> MVP | <input type="checkbox"/> Hay fever | | <input type="checkbox"/> Soreness in jaw | <input type="checkbox"/> Stiff neck, Jaw pain, or TMJ (circle one) |
| <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Joint replacements | | <input type="checkbox"/> Is it hard for you to open wide? | |

What is most important to you about your teeth? _____

How would you rate the appearance of your smile? (Select one) Excellent Good Fair Poor

If you could change anything about your smile, what would it be? _____

Does having dental treatment make you afraid or nervous? Y N If yes, what specific things bother you? _____

Communication Preferences:

Do not leave a detailed message Office may leave a detailed message which may contain medical/dental information at the following phone number(s): Cell Home

Is there anyone other than the patient we may speak to regarding any dental treatment information?

Name of Person: _____ Relationship to Patient: _____

I certify that all the information (including medical, personal, and insurance records) is true and complete. I give my full permission to Dental Care Hillsborough to check and verify my credit and/or employment history. I further understand that Dental Care Hillsborough will assist me in filing my claims, but the insurance coverage I have for dental services can vary and will depend on my insurance plan. I understand that I am responsible for all fees and services. Since our doctors often provide continuing education to other doctors, I give my permission to use my photos for educational purposes. I give permission for phone calls and visits to be recorded for internal training purposes. If the patient is a minor, as the responsible party I give permission, in my absence, to provide examinations, dental cleanings and necessary x-rays as part of routine care for this patient. We require 48 hours advance notice if you are unable to keep your appointment. Failure to do so could result in a charge. Finance charges will be assessed on any account that is 60 days or more past due at the rate of 1.5% per month. Thank you for your cooperation.

Signature of Patient or Guardian: _____ Date: ____ / ____ / ____