WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

1. About You

Today's Date: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called _____ ❑ Male ❑ Female

Birthdate: _____ Age: _____ SS# _____

Home Address: _____

_____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Seperated

Best Contact Number: _____

Cell Number (if different); _____

Email Address: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best time to reach you? _____

Who may we thank for referring you? _____

Other family members seen by us: _____

_____

Previous/Present Dentist: _____

Last Visit Date: _____

2. Spouse Information

Their Name: _____

Employer: _____

Wk# _____ Ext._____SS:_____

Birthdate: _____ DL# _____

Person Responsible for Account

Name: _____

Wk# _____ Ext._____HM#:_____

Billing Address: _____
CITY STATE ZIP

Relationship _____ SS#: _____

Employer: _____

DL# _____

3. Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group #(Plan, Local, or Policy #): _____

Insured' Name _____ Relation: _____

Insured's Birthday: _____ SS#:_____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group #(Plan, Local, or Policy #): _____

Insured' Name _____ Relation: _____

Insured's Birthday: _____ SS#:_____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: _____ Relation: _____

Wk# _____ HM# _____

4. Medical History

Do you have a personal physician? ❑ No ❑ Yes

Medical Doctor's Name: _____

Phone #: _____ Date of last visit: _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ No ❑ Yes

Please explain _____

Are you taking any medication? ❑ No ❑ Yes

Please list each one: _____

Women: Are you taking birth control pills? ❑ No ❑ Yes

Are you pregnant? ❑ No ❑ Yes Week # _____

Are you nursing? ❑ No ❑ Yes

Have you ever had any of the following diseases or medical problems?

Y	N	Heart Attack	Y	N	Anemia
Y	N	Heart Murmur	Y	N	Asthma
Y	N	Heart Surgery	Y	N	Difficulty Breathing
Y	N	Rheumatic Fever	Y	N	Emphysema
Y	N	Pacemaker	Y	N	Tuberculosis
Y	N	Mitral Valve Prolapse	Y	N	Sinus Problems
Y	N	Stroke	Y	N	Sever/Frequent Headaches
Y	N	Congenital Heart Defect	Y	N	Psychiactric Problems
Y	N	Artificial Valves	Y	N	Drug/Alcohol Abuse
Y	N	Artificial Joints	Y	N	HIV / AIDS
Y	N	High Blood Pressure	Y	N	Venereal Disease
Y	N	Blood Transfusion	Y	N	Hepatitus
Y	N	Hemophilla/Abnormal Bleeding	Y	N	Glaucoma
Y	N	Diabetes	Y	N	Epilepsy
Y	N	Kidney Problems	Y	N	Seizures
Y	N	Shingles	Y	N	Fainting Spells

Hospitalized for any reason:

_____

_____

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following drugs?

Y	N	Penicillin	Y	N	Tetracycline
Y	N	Latex	Y	N	Aspirin
Y	N	Dental Anesthetics	Y	N	Other
Y	N	Erythromycin	Y	N	Codeine

Please list any other drugs that you are allergic to: _____

_____

5. Dental History

Why have you come to the dentist today? _____

_____

_____

Are you currently in pain? ❑ No ❑ Yes

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ No ❑ Yes

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/TMD) ❑ No ❑ Yes

Your current dental helath is ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ No ❑ Yes

Do your gums ever bleed? ❑ No ❑ Yes

How many time a week do you floss? ____ a day do you brush_____

Type of bristles? ❑ Hard ❑ Medium ❑ Soft

Our office is committed to meeting or exceeding the standard of infection control mandated by OSHA, HIPPA, the CDC, and the ADA.

Do you experience any of the following symptoms?

Y	N	A persistent cough (i.e., one that has lasted for 3 or more weeks) along with other signs of active TB such as
Y	N	Bloody Sputum
Y	N	Night Sweats
Y	N	Weight loss anorexia
Y	N	Fever

To the best of my knowledge, the information I have furnished is complete and accurate. I accept full financial responsibility for the treatment performed by this office. I authorize release of all information related to my services to my insurance company. Insurance forms will be completed as a convenience to the patient, however, payment to the doctor is expected at the time services are rendered, unless other arrangements are made in advance. If collection proceedings become necessary, I will be responsible for all cost incurred (35% of balance for collection agency and any and all court costs). In addition, my signature on this form is acknowledged authorization for Dr. Hall or his representative to seek a credit report if credit is extended. **I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.**

Signature _____ **Date** _____

Cancellation Policy

We require that you give our office 48 hours notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled for that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. You may be charged a fee $50.