HILLSBOROUGH COMPREHENSIVE DENTAL CARE

Patient Information

Name: _____
Last First MI Title

Preferred Name: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ ZIP: _____

SSN: _____ DOB: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Employer: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed

How did you hear about our office? _____

Do you prefer to be contacted for appointment confirmation via ☐ E-mail ☐ Phone ☐ Both

Insurance – Primary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Do you have additional insurance? ☐Yes ☐No

Appointment Cancellation Policy

When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, **we kindly request that you contact us by phone with advanced notice of two business days.** We understand that conflicts arise; however failing your appointment or canceling without adequate notice will result in a $50 charge per hour of appointment missed and possible discontinuation of services. Initials:_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Hillsborough Comprehensive Dental Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Payment is due in full at time of treatment unless prior arrangements have been approved.

Responsible Party Signature: _____

Relationship: _____ Date: _____

Medical History

Physicians Name_____ Phone number: _____

Approximate date of last visit: _____

Current health condition: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had any serious health problems in the last five years? ☐ Yes ☐ No

If yes, please explain: _____

(For women) Are your currently pregnant? ☐ Yes ☐ No If yes, how many months? _____

Are you currently nursing? ☐ Yes ☐ No Are you currently taking birth control? ☐ Yes ☐ No

Please list prescription medications and vitamin/herbal supplements you are currently taking:

_____

Do you know your blood pressure? ☐ Yes ☐ No If yes, what is it? _____

Please check if you are allergic to any of the following:

☐ Local anesthetics
☐ Penicillin/other antibiotics
☐ Latex sensitivity
☐ Sulfa drugs
☐ Barbiturates, sedatives, sleeping pills
☐ Shellfish, iodine or red wine
☐ Codeine/other narcotics
☐ Aspirin
☐ Other_____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Arthritis/Gout
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problem
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Heart Pace Maker
☐ Heart Trouble/Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Spina Bifida
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

I understand that the information that I have given today is correct to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes in my medical status.

Responsible Party Signature _____

Relationship: _____ Date: _____

Dental History

How may we help you today? _____

Are you currently in pain? ☐ Yes ☐ No

Your current dental health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

How many times a do you: floss/week?_____ brush/day?_____

When was your last dental exam/cleaning? _____ When was the last time you had dental x-rays? _____

Are any of your teeth sensitive to:

Hot or cold?	☐ Yes ☐ No
Sweets?	☐ Yes ☐ No
Biting or Chewing?	☐ Yes ☐ No

Have you ever had:

Orthodontic treatment?	☐ Yes ☐ No
Oral surgery?	☐ Yes ☐ No
Periodontal/Gum treatment?	☐ Yes ☐ No
Mouthguard/Nightguard?	☐ Yes ☐ No

Smile Analysis

Are you happy with your smile?	☐ Yes ☐ No
Are you happy with the color of your teeth?	☐ Yes ☐ No
Would you like to improve your smile?	☐ Yes ☐ No

Do you:

Notice any bad taste or odor?	☐ Yes ☐ No
Frequently get cold sores or blisters?	☐ Yes ☐ No
Have bleeding gums?	☐ Yes ☐ No
Have loose teeth?	☐ Yes ☐ No
Get food caught between your teeth?	☐ Yes ☐ No
Clench or grid your teeth?	☐ Yes ☐ No
Have tired or tender jaws?	☐ Yes ☐ No
Have clicking or popping of the jaw?	☐ Yes ☐ No
Bite your lips/cheeks regularly?	☐ Yes ☐ No
Difficulty opening or closing your mouth?	☐ Yes ☐ No
Mouth breathe?	☐ Yes ☐ No
Snore or have Sleep Apnea?	☐ Yes ☐ No
Smoke and/or chew tobacco?	☐ Yes ☐ No

Why did you leave your previous dentist?

_____

Have you ever had an upsetting dental experience? Please describe

_____

How can we accommodate you better during your dental visit?

_____

Here at Hillsborough Comprehensive Dental Care we offer a wide variety of services to enhance and keep your smile beautiful. Please check any services below you would like our friendly staff to discuss with you during your visit.

☐ Tooth Whitening
☐ Veneers
☐ Invisalign
☐ Smile Makeover
☐ Bonding
☐ Sealants
☐ Crown and Bridge
☐ Implant Crowns
☐ Partials/Dentures
☐ Night/Sport Guard

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Responsible Party Signature _____

Relationship: _____ Date: _____