

Account Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Address: _____ Apartment # _____
Street
City State Zip Code

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____

E-mail: _____ Cell Phone # _____

Preferred time for us to phone you: _____

Who may we thank for referring you to our practice? _____

May we mention you in our newsletter? Yes or No

Employed by _____ City: _____ State _____

Your dental insurance company and address (thru your employer) _____
Group # _____

Member ID # _____

How long have you had insurance _____ Who is covered under it _____

Spouse information: Name _____ Birth date _____

Social Security # _____ Spouses employer _____ City _____ State _____

Spouse's dental ins co. and address (thru his/her employer) _____
Group # _____

Member ID # _____

How long have you had this insurance _____ Who is covered under it _____

Who is responsible for this account _____

Rather than paying the insurance portion on the day that treatment is provided, I request all insurance benefits be paid directly to HealthPark. Signature _____

Consent for Services

Previous dentist _____

Address _____

Phone _____ City _____ State _____

Physician's Name _____

Address _____

Phone _____ City _____ State _____

I hereby authorize HealthPark Dentistry to speak with any health care practitioner who has treated, or is treating me, about past or present medical or dental diagnosis, treatment or conditions. This authorization includes the releases of my dental and medical records to HealthPark Dentistry as s/he reasonably deems necessary. This authorization will remain valid until revoked by me in writing.

To the best of my knowledge, all of the answers are true and correct. If there is ever a change in my health history, or if my medicines change, I will inform this office at the next appointment without fail.

Signature of patient, parent, or guardian _____ Date _____

Medical History

- Are you in good health? Excellent Good Fair Poor
- Date of last physical exam? _____
- Have you been under the care of a physician in the last 2 years? Yes No
If so, what for: _____
- Have you had any serious illnesses, operations or hospitalizations? Yes No
If so, what for: _____

Do you have or have you ever had any of the following? Please check those that apply:

- | | | |
|--|---|--|
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Arthritis or rheumatism | <input type="checkbox"/> AIDS/HIV+ |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer, radiation/chemotherapy |
| <input type="checkbox"/> Heart Problems/pacemaker | <input type="checkbox"/> Hives or skin rash | <input type="checkbox"/> Hepatitis, Jaundice, or Liver Disease |
| <input type="checkbox"/> Asthma/hay fever | <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Seizures/ Epilepsy or Tuberculosis |
| <input type="checkbox"/> Heart Valve damage | <input type="checkbox"/> Artificial bones, joints | <input type="checkbox"/> Reaction to metal jewelry, nickel |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Blood disorders (anemia) | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Alcohol, chemical dependency | <input type="checkbox"/> Sickle Cell disease |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Beta Blockers – Indersol, Corgard | <input type="checkbox"/> Biophosphonates (Fosamax) | |

- Have you had any unusual bleeding episodes _____
- Have you ever had any unusual reactions or allergies to food, drugs or latex? _____
If yes, please explain: _____

• Please list any drugs, herbs, vitamins, aspirin, birth control pills, etc. you are taking and the problems for which they are taken.

Medication _____	Taken For _____
Medication _____	Taken For _____
Medication _____	Taken For _____
Medication _____	Taken For _____

- Have you ever had any trouble with previous medical or dental treatment? Yes No
If yes, please explain: _____

- Are you in any situation which regularly exposes you to x-rays? Yes No
- Have you been hospitalized in the last five years? yes no
- Have you ever had a blood transfusion? yes no
- (Women) Are you pregnant? Yes or No
- Is there anything else about your health I should know: _____

Signature of Dentist _____ Date _____

Date Updated _____ Date Updated _____ Date Updated _____ Date Updated _____

Dental History

1. What is the chief reason you've come to our office now? _____

2. When was the last time:
You went to the dentist: _____ You had a complete exam: _____
You had a full mouth set of x-rays: _____ You had your teeth cleaned: _____
3. Do you feel you've required much dental care in the past? Yes No
If yes, has it been to replace previous dentistry or repair newly decayed areas: _____
4. Have you ever had any teeth removed (extracted)? Yes No
When _____ Why _____
5. What did you like most or least about how you were treated by your previous dentist? _____

6. Have you ever worn braces yes no
7. Do you have a complete or partial denture? Yes No If yes, is it: Upper Lower
How old is it? _____ Are you satisfied with it? _____
8. How would you describe the general condition of your teeth now? Poor Average Excellent
9. What would you like the general condition of your teeth to be: ? Poor Average Excellent
10. To reach this level of dental health, how much treatment will you need? Very little Some A lot
11. What treatment concerns do you have? _____
12. If you could change anything about your smile, what would it be? _____
13. Do you snore enough to bother your spouse? Yes No
14. Decay and gum disease potential:
Have you had a decay problem in the past? Yes No Do you have a dry mouth? Yes No
Have you noticed that you have bad breath? Often Occasionally No
How often do you have sugar (including soft drinks, mints, coffee with sugar) during the day? _____
Have you had regular dental cleanings? Yes No
How do you take care of your teeth? _____
Have you ever had gum surgery? _____
Do your gums bleed? _____
Does food get caught between any of your teeth routinely? _____
Do any of your teeth feel loose? _____
15. Do your jaws feel tired when you wake in the morning? Yes No
16. Have you had any injury to your jaws? _____
17. Do you chew on both sides of your mouth? _____
18. Are you experiencing any: Clenching Grinding of teeth Clicking/popping jaw Headaches
19. Do you have any tooth sensitivity due to heat, cold, sweets, or while biting or chewing? Yes _____
No _____
20. Is it hard for you to relax during dental treatment? No Slightly Moderately Extremely
21. What can we do to make you more comfortable? _____
22. Diet: What do you often drink besides water? _____
Number of times per day _____
How long to finish a drink? _____
23. How often do you eat/consume desserts, candy, sugar, gum? _____ times per day
24. Are you deeply concerned about the finances required to return your mouth to dental health? Yes No
25. So that we can get to know you better, would you mark the activities you most enjoy? Travel Reading
 Sports Movies Cooking Music Art Fishing Other _____

Acknowledgement of Receipt of Notice of Privacy Practices

*you may refuse to sign this Acknowledgement *

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtainng acknowledgement
- Other (please specify)

