Chart #: __________
FOR OFFICE USE ONLY

Account Information

Patient Name: ____ Date: ___________
Last, First MI (Preferred Name)

Address: ____
Street Apartment #

____
City State Zip Code

Social Security #: _________________________ Birth Date: _________________________

Phone (Home): _____________ (Work): ______________ Ext: ________ E-mail: _________________

Cell Phone #-____________________________ Fax # ____________________________

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:

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

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

- 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 you are taking and the problems for which they are taken. (including aspirin, herbs, birth control pills, etc.)

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:____

____

- Who told you about our practice?____________________ Why did you select HealthPark __________________

Signature of Dentist ____Date ________________________

Date Updated ____________ Date Updated ____________ Date Updated ___________ Date Updated ___________

Dental History

1. What is wrong with your present dentures? ____
2. Do you think this will require new dentures or relining of your present ones? ______________________________
3. How old are your present dentures? ____
4. How many dentures have you had: upper _____________ lower _________________
5. Have your present dentures been relined? ☐ Yes ☐ No How long ago? ________________________________
6. Did you have much trouble getting used to your present dentures when they were new? ___________________
   Please explain: ____
7. Have you been successful wearing your dentures? ____
8. If new dentures are made, what changes would you like? ____

Remove wrinkles ___________________	Improve comfort __________________________
Improve speech ___________________	Good fit__________________________________
Improve chewing ___________________	Improve appearance______________________

9. All people don't have good ridges to support their dentures. How are your ridges: Good___ Fair___ Poor____
10. How long were you without teeth before your first dentures were made? _______________________________
11. Do you like the way your dentures look? ____
12. Do your dentures look like dentures or natural teeth? ____
13. How well have you been treated by your past dentists? ☐ Poor ☐ Fair ☐ Good
14. Are you now under stress or will you be under much stress soon?
15. Do you use glue in your dentures? ____
16. Does food get under your dentures? ____
17. Do your dentures cause sores in your mouth? ____
18. Do you wear your dentures day and night? ____
19. Do you get many headaches or neck and shoulder pain? ____
20. Do you get ringing or pain in or around your ears? ____
21. Do the muscles of your face feel tired in the morning?____
22. Are you aware of clenching or grinding your teeth?____
23. If you open wide, does your joint click or pop?____
24. Have you had any injury to your jaws?____
25. Are you deeply concerned about the finances required to return your mouth to dental health?____________
26. What can we do to make you more comfortable?____
27. Do you snore enough to bother your spouse? Yes ___ No ___
28. Do you spend significant time around others in business or social settings? ___________________________

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:

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