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 # -«OtherPhone»_____ Fax # _____

Preferred time for us to phone you AM _____ PM _____May we mention you in our newsletter? Yes or No

Preferred appointment time: AM _____ PM _____ Preferred day: Mon Tues Wed Thurs Fri Sat Any_____

How did you hear about HealthPark Dentistry? _____

Employed by_____ City:_____ State _____

Your dental insurance company and address (thru your employer) _____
_____Group #_____
Member ID # _____

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 _____

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 deemed necessary, and records can be sent/received via email. 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

I authorize HealthPark Dentistry to use my name and photo in promotional materials such as newsletters, testimonials, and social media posts.

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

- 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: _____

Due to recent federal regulations we need your permission to receive a phone call, text, or mail message from us:

Yes: _____ No: _____

Annual consent update: Initials:_____ Date Updated _____ Initials: ____Date Updated _____

Initials: _____ Date Updated _____ Initials: _____ Date Updated: _____

Initials: _____ 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. Is there anyone you would like to bring with you to make significant dental decisions? _____

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)

_____

_____

_____