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 _____

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

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 _____

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 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:

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

_____

_____

_____