MEDICAL/DENTAL HISTORY

HIDDEN LAKES DENTAL CARE

Dental History

	Yes	No
Do you have a specific problem? Describe _____	❑	❑
Do you have regular dental examinations? Last visit _____	❑	❑
Do you think you have active decay or gum disease? Describe _____	❑	❑
Do you brush and floss regularly? ❑ Brush ___/day Toothbrush is: soft medium hard ❑ floss ___/day	❑	❑
Do your gums bleed? Discuss_____	❑	❑
What would you like to change about your smile?_____		
Does food catch between teeth? Any loose teeth?_____	❑	❑
Do you ever have popping, clicking or discomfort in the jaw joint? Do you brux or grind? _____	❑	❑
Does dental treatment make you nervous? ❑ No ❑ Slightly ❑ Moderately ❑ Extremely		
Do you smoke or use chewing tobacco? Any sores or growths in your mouth? Describe _____	❑	❑
Have you ever been treated for periodontal disease (gum disease, pyorrhea)?_____	❑	❑
Date of last full mouth x-rays (~ 16 small films) _____		

Medical History

Are you under a physician's care now? Whom? Why? _____	❑	❑
Have you ever been hospitalized or had a major operation? Discuss _____	❑	❑
Have you ever had a serious injury to your head/neck? Discuss_____	❑	❑
Are you taking any medications, pills or drugs? What?_____	❑	❑
Have you taken weight reduction medication Fen-Phen in the past? _____	❑	❑
Are you allergic to any medications or substances? Discuss/mark below_____	❑	❑
❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Anesthetic ❑ Acrylic ❑ Metal ❑ Other_____		
WOMEN(Please check): ❑ Pregnant ❑ Trying to get pregnant ❑ Nursing ❑ Taking birth control ❑ Taking estrogen	❑	❑
Do you wish to speak to the dentist about any problem?_____		

Please check the appropriate box for each condition

	YES	NO		YES	NO		YES	NO		YES	NO
Heart Disease	❑	❑	Hemophilia	❑	❑	AIDS	❑	❑	Cancer	❑	❑
Heart Murmur	❑	❑	Leukemia	❑	❑	HIV Positive	❑	❑	Chemotherapy	❑	❑
Irregular Heart Beat	❑	❑	Blood Transfusion	❑	❑	Genital Herpes	❑	❑	Radiotherapy	❑	❑
Angina/Chest Pain	❑	❑	Swelling of Limbs	❑	❑	Chemical Addiction	❑	❑	Diabetes	❑	❑
Heart Attack/Failure	❑	❑	Lung Disease	❑	❑	Cortisone Medication	❑	❑	Emphysema	❑	❑
Congenital Heart	❑	❑	Breathing Problem	❑	❑	Cold Sores	❑	❑	Hypoglycemia	❑	❑
Mitral Valve Prolapse	❑	❑	Shortness of Breath	❑	❑	Fever Blisters	❑	❑	Ulcers	❑	❑
Scarlet Fever	❑	❑	Frequent Cough	❑	❑	Herpes	❑	❑	Anemia	❑	❑
Rheumatic Fever	❑	❑	Hay Fever	❑	❑	Stroke	❑	❑	Excessive Bleeding	❑	❑
Artificial Heart Valve	❑	❑	Sinus Trouble	❑	❑	Convulsions	❑	❑	Sickle Cell Disease	❑	❑
Pacemaker	❑	❑	Asthma	❑	❑	Epilepsy/Seizures	❑	❑	Arthritis/Gout	❑	❑
Heart Surgery	❑	❑	Yellow Jaundice	❑	❑	Fainting/Dizziness	❑	❑	Rheumatism	❑	❑
High Blood Pressure	❑	❑	Kidney Problems	❑	❑	Glaucoma	❑	❑	Pain in Jaw Joint	❑	❑
Low Blood Pressure	❑	❑	Renal Dialysis	❑	❑	Nervousness	❑	❑	Allergies(medicine)	❑	❑
Blood Disease	❑	❑	Thyroid Disease	❑	❑	Psychiatric Care	❑	❑	Tumors/Growths	❑	❑
Bruise Easily	❑	❑	Parathyroid Disease	❑	❑	Alzheimer's Disease	❑	❑	Hepatitis	❑	❑

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health or my medications change, I will bring it to the attention of the dentist and staff at the next appointment without fail.

X_____ Date_____

PATIENT SIGNATURE(PARENT/GUARDIAN, IF MINOR)

FOR OFFICE USE ONLY

❑ History reviewed by Doctor ____ (Initials)

❑ ALLERGIES: ❑ none ❑ _____

❑ SIGNIFICANT FINDINGS: ❑ none ❑ _____

PATIENT NAME_____

PATIENT REGISTRATION FORM

HIDDEN LAKES DENTAL CARE

PLEASE PRINT CLEARLY

NAME(LAST, FIRST, MIDDLE)		ADDRESS(INCLUDE CITY, STATE, ZIP)	
BIRTHDATE	SEX ❑ MALE ❑ FEMALE	MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED	
HOME PHONE ( )	WORK PHONE ( )	CELL PHONE ( )	MAY WE SEND TEXT APPT REMINDERS? ❑ YES ❑ NO SOCIAL SECURITY #
EMPLOYER		EMPLOYER ADDRESS(INCLUDE CITY, STATE, ZIP)	
ARE YOU A FULL-TIME STUDENT? IF YES, NAME/LOCATION OF SCHOOL ❑ YES ❑ NO		WHO IS RESPONSIBLE FOR THIS ACCOUNT?	
DRIVERS LICENSE NO.		E-MAIL ADDRESS (TO RECEIVE E-NEWSLETTER, SPECIAL PROMOTIONS, ETC.)	

SPOUSE (Parent, if child/minor)

NAME(LAST, FIRST, MIDDLE)		ADDRESS(INCLUDE CITY, STATE, ZIP)
HOME PHONE ( )	WORK PHONE ( )	PRESENT POSITION
EMPLOYER		EMPLOYER ADDRESS(INCLUDE CITY, STATE, ZIP)
DRIVERS LICENSE NO.		

DENTAL INSURANCE

EMPLOYEE NAME(LAST, FIRST, MIDDLE)	EMPLOYEE BIRTHDATE	EMPLOYEE SOCIAL SECURITY #
EMPLOYER	INSURANCE COMPANY	UNION/LOCAL #/GROUP #

DENTAL INSURANCE(SECONDARY)

EMPLOYEE NAME(LAST, FIRST, MIDDLE)	EMPLOYEE BIRTHDATE	EMPLOYEE SOCIAL SECURITY #
EMPLOYER	INSURANCE COMPANY	UNION/LOCAL #/GROUP #

NEAREST RELATIVE NOT LIVING WITH YOU

NAME(LAST, FIRST, MIDDLE)		ADDRESS(INCLUDE CITY, STATE, ZIP)
HOME PHONE ( )	WORK PHONE ( )	RELATIONSHIP

PERSON TO NOTIFY IN CASE OF EMERGENCY

NAME(LAST, FIRST, MIDDLE)		ADDRESS(INCLUDE CITY, STATE, ZIP)
HOME PHONE ( )	WORK PHONE ( )	RELATIONSHIP

WHOM MAY WE THANK FOR THIS REFERRAL?

❑ PROMOTIONAL PIECE ❑ YELLOW PAGES ❑ INSURANCE CO. ❑ FRIEND/RELATIVE(NAME_____)
so we may thank them
❑ LOCATION ❑ OTHER_____

I certify that all of the above information is accurate and correct. I authorize the dentist or his employees to perform all diagnostic procedures and treatments as may be necessary for proper dental treatment(determined by the dentist and/or his employees). I authorize the release of any information concerning my or my child's health care, advice and treatment provided for the purpose of evaluating and administering insurance benefits; as well as providing said information to another healthcare provider. I authorize payment of all insurance benefits otherwise payable to me directly to the dentist or dental group. If I do not pay my entire Balance within 25 days of the monthly billing date, I understand a FINANCE/BILLING charge may be applied to my account for the current monthly billing period. The FINANCE CHARGE will be a periodic rate of 1.5% per month (or a minimum of $2.50, whichever is more) which is an ANNUAL PERCENTAGE RATE of 18% applied to last month's balance. In the case of a default of payment I promise to pay a $25 collection fee and, in addition, any legal interest on the balance due, together with any collection cost and reasonable attorney's fees incurred to effect collection on this account.

SIGNATURE	**DATE**