Hurstbourne Dental Care

Welcome!

Thank you for selecting our dental healthcare team! Our goal is to provide you with the best possible dental care.
To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions, or need any assistance, we will be happy to help.

Patient Information (Confidential)

Name_____ SSN# _____ Date_____

Home Phone_____ Cell Phone_____

Address_____ City_____ State_____ Zip Code_____

Email_____ Date of Birth_____

Check Appropriate Box: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

If student, name of school/college_____ City_____ State_____ □Full-time □Part-time

Patient or Parent/Guardian's employer_____ Work Phone_____

Business Address_____ City_____ State_____ Zip Code_____

Spouse or Parent/Guardian's Name_____ Employer_____ Work Phone_____

Whom may we thank for referring you?_____

How did you find us?_____

Person to contact in case of emergency_____Phone_____

Responsible Party

Name of person responsible for this account_____Relationship to patient_____

Address_____ Home Phone_____

Email_____ Cell Phone_____

Drivers License #_____ Date of Birth_____ Financial Institution_____

Employer_____ Work Phone_____ SS#/SIN_____

Is this person a patient in our Office? □ YES □ NO

For your convenience, we offer the following methods of payment (Please check the option you prefer):

□ Cash □ Personal Check Credit Card □ VISA □ MC □ I wish to discuss the office's payment policy

Insurance Information

Name of Insured_____Relationship to Patient_____

Date of Birth_____SS#/SIN_____Date Employed_____

Name of Employer_____Union or Local #_____Work Phone_____

Address Of Employer_____City_____ State_____ Zip Code_____

Insurance Company_____ Group#_____ Policy/ ID#_____

Insurance Company Address_____ City_____State_____ Zip Code_____

How much is your deductible?_____How much have you used?_____Max. Annual Benefit_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? □ YES □NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured_____Relationship to Patient_____

Date of Birth_____SS#/SIN_____Date Employed_____

Name of Employer_____Union or Local #_____Work Phone_____

Address Of Employer_____City_____ State_____ Zip Code_____

Insurance Company_____ Group#_____ Policy/ ID#_____

Insurance Company Address_____ City_____State_____ Zip Code_____

How much is your deductible?_____How much have you used?_____Max. Annual Benefit_____

Hurstbourne Dental Care

Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam_____

YES/NO

1. Are you under medical treatment right now?..... ☐ ☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?..... ☐ ☐

If yes, please explain_____

_____

_____

3. Are you taking any medication(s) including non-prescription medicine?..... ☐ ☐

If yes, what medication(s) are you taking?

_____

_____

_____

4. Have you ever taken Fen-Phen/Redux?..... ☐ ☐
5. Do you use Tobacco?..... ☐ ☐
6. Do you use controlled substances?..... ☐ ☐
7. Are you wearing contact lenses?..... ☐ ☐
8. Are you taking any blood thinners?..... ☐ ☐

Name of Prescription: _____

9. Have you ever taken Bisphosphonate Medication for Osteoporosis (Ex. Fosamax, Reclast)?..... ☐ ☐

Date:_____ Duration: _____

YES/NO

10. Are you allergic to or have you had any reactions to any of the following?

Local Anesthetics (e.g. Novocain)..... ☐ ☐
Penicillin or other Antibiotics..... ☐ ☐
Sulfa Drug..... ☐ ☐
Barbiturates..... ☐ ☐
Sedatives..... ☐ ☐
Iodine..... ☐ ☐
Aspirin..... ☐ ☐
Any Metals (e.g. nickel, mercury, etc..... ☐ ☐
Latex Rubber..... ☐ ☐
Other_____

11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)..... ☐ ☐
12. Women only:

a) Are you pregnant or think you may be?..... ☐ ☐
b) Are you nursing?..... ☐ ☐
c) Are you taking oral contraceptives?..... ☐ ☐

Do you have any of the following?

YES/NO

High Blood Pressure..... ☐ ☐
Heart Attack..... ☐ ☐
Rheumatic Fever..... ☐ ☐
Swollen Ankles..... ☐ ☐
Fainting/Seizures..... ☐ ☐
Tuberculosis..... ☐ ☐
Asthma..... ☐ ☐
Low Blood Pressure..... ☐ ☐
Epilepsy/ Convulsions..... ☐ ☐
Leukemia..... ☐ ☐
Diabetes..... ☐ ☐
Kidney Diseases..... ☐ ☐
AIDS or HIV Infection..... ☐ ☐
High Cholesterol..... ☐ ☐

YES/NO

Heart Disease..... ☐ ☐
Cardiac Pacemaker..... ☐ ☐
Heart Murmur..... ☐ ☐
Angina..... ☐ ☐
Frequently Tired..... ☐ ☐
Mitral Valve Prolapse..... ☐ ☐
Anemia..... ☐ ☐
Emphysema..... ☐ ☐
Cancer..... ☐ ☐
Arthritis..... ☐ ☐
Joint Replacement or Implant.... ☐ ☐
Hepatitis/ Jaundice..... ☐ ☐
Sexually Transmitted Disease..... ☐ ☐

YES/NO

Chest Pains..... ☐ ☐
Easily Winded..... ☐ ☐
Stroke..... ☐ ☐
Hay Fever/ Allergies..... ☐ ☐
Human papillomavirus. (HPV) ☐ ☐
Stomach Problems/ Ulcers..... ☐ ☐
Chemo/Radiation Therapy..... ☐ ☐
Glaucoma..... ☐ ☐
Recent Weight Loss..... ☐ ☐
Liver Disease..... ☐ ☐
Heart Trouble..... ☐ ☐
Respiratory Problems..... ☐ ☐
Thyroid Problem..... ☐ ☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for the services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of Patient (or parent if minor)

Hurstbourne Dental Care

Patient Dental History

Name of previous dentist and location_____

Date of last exam_____ Date of last cleaning_____

What is your main goal that you would like to get out of your appointment today?

_____

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/food?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck, or jaw injuries?	☐	☐
7. Have you ever experienced any of the following		
Clicking?	☐	☐
Pain? (joint, ear, side of face)	☐	☐
Difficulty in opening or closing?	☐	☐
Difficulty in chewing?	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips/cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you ever had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement_____		
15. Have you ever received oral hygiene instructions?	☐	☐

16. What type of dental work have you had done in the past?

_____

17. What did you like or dislike about your prior dental experiences?

_____

_____

18. How would you rate the overall health of your gums and teeth on a scale of 1 to 10 (1 being very bad and 10 being perfect)?

Very Bad *Perfect*

1 2 3 4 5 6 7 8 9 10

19. Where would you like to be able to rate yourself on that scale, and what would need to happen to get you there?

_____

_____

20. Classify the purpose of your visit into the following categories. (Circle all that apply)

A. Identify small issues before they become larger much more costly issues in the future
B. I like how my teeth feel after they have been cleaned
C. Cosmetic or smile enhancement purposes
D. Pain relief
E. Proactively preserve my natural teeth

Hurstbourne Dental Care

Acknowledgment of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment.
If refused, we will not be allowed to process your insurance claims.

THE PATIENT ABOVE AUTHORIZES HURSTBOURNE DENTAL CARE TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to **Hurstbourne Dental Care** to use my address, phone number, email address and clinical records to contact me to confirm appointments, remind me about check-ups, and to send birthday/holiday related cards.

- I give **Hurstbourne Dental Care** permission to leave a message about my appointment on my answering machine.

- By signing this form you are giving **Hurstbourne Dental Care** permission to use and disclose your protected health information in accordance with the directives listed above.

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

Please Print Name _____

Signature _____

Date _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

_____