Hurstbourne Dental Care

WELCOME! Thank you for selecting our dental healthcare team! Our goal is to provide you with the best possible dental care. Please ask if you have any questions or need any assistance.

Patient Information (Confidential)

Name SSN# Date

Home Phone Cell Phone

Address City State Zip Code

Date of Birth Email

Drivers License #

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse or Parent/Guardian's Name

If student, name of school/college City State ☐ Full-time ☐ Part-time

Whom may we thank for referring you?

How did you find us?

Emergency Contact Phone

Employer Information (Patient)

Employer Union or local #

Work Phone Date Employed

Responsible Party

☐ Check if patient is the Responsible Party

Name of person responsible for this account Relationship to patient

Address City Email

Home phone # SS#/SIN Cell Phone

Date Employed Drivers License # Date of birth

Employer Union or Local # Work Phone

Is this person a patient in our office? ☐ Yes ☐ No

Insurance Information

☐ Check if you do not have insurance

Insurance Company Group# Policy/ ID#

☐ Same as Responsible Party ☐ Same as Patient

Name of insured Relationship to Patient

Date Employed SS#/SIN Date of birth

Date of birth Union or Local # Work Phone

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO

Insurance Company Group # Policy/ID #

☐ Same as Responsible Party ☐ Same as Patient

Name of Insured Relationship to patient

Date of Birth Date Employed SS#/SIN

Employer Union or Local # Work Phone

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.

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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 or are you currently taking Bisphosphonates (Ex. Aredia, Zometa, Didronel, Actonel, Skelid, Fosamax)?..... ☐ ☐

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. Have you taken Cortisone, Prednisone or other steroids within the last 12 months?..... ☐ ☐
13. Are you required to take antibiotics prior to any Dental procedure?..... ☐ ☐
14. 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		YES/NO		YES/NO	
High Blood Pressure.....	☐	☐	Heart Disease.....	☐	☐	Chest Pains.....	☐	☐
Heart Attack.....	☐	☐	Cardiac Pacemaker.....	☐	☐	Easily Winded.....	☐	☐
Rheumatic Fever.....	☐	☐	Heart Murmur.....	☐	☐	Stroke.....	☐	☐
Swollen Ankles.....	☐	☐	Angina.....	☐	☐	Hay Fever/Allergies.....	☐	☐
Fainting/Seizures.....	☐	☐	Frequently Tired.....	☐	☐	Human papillomavirus. (HPV)	☐	☐
Tuberculosis.....	☐	☐	Mitral Valve Prolapse.....	☐	☐	Stomach Problems/ Ulcers.....	☐	☐
Asthma.....	☐	☐	Anemia.....	☐	☐	Chemo/Radiation Therapy.....	☐	☐
Low Blood Pressure.....	☐	☐	Emphysema.....	☐	☐	Glaucoma.....	☐	☐
Epilepsy/ Convulsions.....	☐	☐	Cancer.....	☐	☐	Recent Weight Loss.....	☐	☐
Leukemia.....	☐	☐	Arthritis.....	☐	☐	Liver Disease.....	☐	☐
Diabetes.....	☐	☐	Joint Replacement or Implant....	☐	☐	Heart Trouble.....	☐	☐
Kidney Diseases.....	☐	☐	Hepatitis/ Jaundice.....	☐	☐	Respiratory Problems.....	☐	☐
AIDS or HIV Infection.....	☐	☐	Sexually Transmitted Disease....	☐	☐	Thyroid Problem.....	☐	☐
High Cholesterol.....	☐	☐						

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)

_____

_____