PATIENT INFORMATION

Date__________________

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name__________________ M.I.______ Last Name______________________ Preferred Name_______________

Sex: ❑ Male ❑ Female Birth Date________________ Age______ Soc. Sec. #________________ E-mail________________________________

Street____ City_______________________________ State _______ Zip_________________

Home Tel.(______) __________________Cell (_______) ____________________ Bus. Tel.(_____)___________________

Your Employer____ Driver's Lic.#_______________________________

Former Dentist__________________________ Medical Doctor___________________________ Referred By_____________________________

Nearest relative not living with you___________________________________ Relationship__________________ Tel.(______)_______________

Have you ever been a patient of our practice? ❑ Yes ❑ No Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

How would you like notification of your upcoming appointments: ❑ email ❑ text ❑ phone call

Who will be responsible for your account?

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other___________________

(If self, skip to next section)

Name__________________________________ S.S.#_______________________ Birth Date______________ Age______________________

Street____ City___________________ State_________ Zip______________________

Tel.(____)______________________Employer____ Bus. Tel.(_____)____________________

Spouse or other guarantor information *(if different from above)*

Name___________________________ Relation_____________________ S.S.#______________________ Birth Date___________________

Street____ City__________________________ State__________ Zip__________________

Tel. (____)_____________________ Employer _________________________________Bus. Tel.(____)______________________________

INSURANCE INFORMATION

Student: ❑ Full Time ❑ Part Time ❑ Not School Name/Address_________________________

❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single ____________________________

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not Do you belong to a PPO or HMO? ❑ Yes ❑

PRIMARY DENTAL INSURANCE

Employer____

Bus. Address____

Bus. Tel.(____) ________________ Plan____________________

Ins. Co. Name____

Address____

_____________________Tel.(____)________________________

Group #__________________Group Name_________________

Insured Party_____________________ Relation_____________

Sex: ❑ M ❑ F Birth Date________________________

Street____

City, State, Zip____

Tel.(___)________________ S.S. #_______________________

I.D. #____

SECONDARY DENTAL INSURANCE

Employer____

Bus. Address____

Bus. Tel.(____) ________________ Plan____________________

Ins. Co. Name____

Address____

_____________________Tel.(____)________________________

Group #__________________Group Name_________________

Insured Party_____________________ Relation_____________

Sex: ❑ M ❑ F Birth Date________________________

Street____

City, State, Zip____

Tel.(___)________________ S.S. #_______________________

I.D. #____

DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Consultation ❑ Emergency   Are you in pain? ❑ Yes ❑ No For How Long? ______________________

Please indicate any of the following problems by checking off the corresponding box:

❑ Discomfort, clicking, or popping in jaw
❑ Red, swollen, or bleeding gums
❑ A removable dental appliance
❑ Blisters / sores in or around the mouth
❑ Prolonged bleeding from an injury / extraction
❑ Recent infections or sore throat
❑ My teeth are sensitive to: ❑ Hot ❑ Cold ❑ Sweets ❑ Biting
❑ Lost / broken filling(s)
❑ Teeth grinding / clenching
❑ Ringing in ears
❑ Broken / chipped tooth
❑ Gum disease
❑ Toothache
❑ Stained teeth
❑ Difficulty opening jaw
❑ Difficulty closing jaw
❑ Burning tongue / lips
❑ Swelling / lumps in mouth
❑ Previous Periodontal Treatment
❑ Other:____
❑ Orthodontics
❑ Bad breath
❑ Loose / shifting teeth
❑ Food caught between teeth

Last dental exam__________________ Last dental x–rays________________ Times a day you brush?_________ Times a week you floss?_________

What type of tooth bristles do you use? ❑ Soft ❑ Medium ❑ Hard   How would rate your smile? *(worst)* 1 2 3 4 5 6 7 8 9 10 *(best)*

How would rate your dental anxiety? *(low)* 1 2 3 4 5 6 7 8 9 10 *(high)*

Have you ever been told you need pre-medication before coming to a dental office? *(please circle one)* Yes No

Chief dental complaint at this time? ____

Do you drink soda? _______ Regular or Diet?___________ How many per day?____________

Do you drink coffee? ______ With cream or sugar?________ How many cups per day?________

Do you drink tea? ________ With lemon or sugar?_________ How many cups per day?________

Do you drink sports drinks/ juice/energy drinks/other?_____________ How many per day?________

MEDICAL HISTORY

Are you in good health? ❑ Yes ❑ No   Height ________________ Weight ______________

Are you under the care of a physician? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y N
❑ ❑ Alzheimer's/Memory Loss
❑ ❑ Anemia
❑ ❑ Anorexia/Bulimia
❑ ❑ Arthritis
❑ ❑ Artificial Joints
❑ ❑ Artificial Heart Valves
❑ ❑ Asthma
❑ ❑ Blood Transfusions
❑ ❑ Cancer/Chemotherapy
❑ ❑ Radiation Treatments
❑ ❑ Cold Sores/Herpes
❑ ❑ Congenital Heart Defect
❑ ❑ Diabetes
❑ ❑ Difficulty Breathing
❑ ❑ Drug/Alcohol Abuse
❑ ❑ Emphysema
❑ ❑ Epilepsy/Seizures
❑ ❑ Fainting/Dizzy Spells
❑ ❑ Gastrointestinal Disorder

Y N
❑ ❑ Glaucoma (Narrow Angle)
❑ ❑ Hay Fever
❑ ❑ Headaches (Severe, Frequent)
❑ ❑ Hearing Impaired
❑ ❑ Heart Attack
❑ ❑ Heart Murmur
❑ ❑ Mitral Valve Prolapse
❑ ❑ Heart Surgery
❑ ❑ Hemophilia/Abnormal Bleeding
❑ ❑ Hepatitis A B C D
❑ ❑ High Blood Pressure
❑ ❑ Low Blood Pressure
❑ ❑ HIV/AIDS
❑ ❑ Kidney Problems
❑ ❑ Liver Disease
❑ ❑ Migraines
❑ ❑ Other Medical Conditions
❑ ❑ Pacemaker
❑ ❑ Previous Biopsies

Y N
❑ ❑ Recurrent Illnesses
❑ ❑ Rheumatic/Scarlet Fever
❑ ❑ Shingles
❑ ❑ Slow-Healing Mouth Sores
❑ ❑ Smoking Tobacco
❑ ❑ Chewing Tobacco
❑ ❑ Sinus Problems
❑ ❑ Stroke
❑ ❑ Snoring
❑ ❑ Sleep Apnea
❑ ❑ Tuberculosis
❑ ❑ Thyroid Trouble: ❑ Hypo, ❑ Hyper
❑ ❑ Tumor Growth
❑ ❑ Venereal Disease (Sexually Transmitted Disease)

For Women:
❑ ❑ Is there a possibility of pregnancy?
❑ ❑ Are you nursing?
❑ ❑ Are you taking birth control pills?

Do you feel well rested after sleeping? ____

Do you ever get light-headed or dizzy? ____

Do you have neck or back pain? ____

Have you ever had head or neck trauma or been in a motor vehicle accident? ____

MEDICATION AND ALLERGIES

Please list any medications you are currently taking *(including over the counter medicines)*

Current Medications (include over the counter and supplements) **Reason**

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Do you pre-medicate prior to dental work: ❑ Yes ❑ No If yes, please list:______________________________

Are you allergic to or had a reaction to:

Y N	Y N	Y N	Y N
❑ ❑ Penicillin	❑ ❑ Sulfa drugs	❑ ❑ Local anesthetic (numbing med)	❑ ❑ Sodium pentothal
❑ ❑ Valium or other tranquilizers	❑ ❑ Aspirin	❑ ❑ Codeine or other narcotics	❑ ❑ Latex
❑ ❑ Soy	❑ ❑ Eggs / Yolk	❑ ❑ Sulfites	❑ ❑ Amoxicillin

Please list any other medication or antibiotic you are allergic to:

____

____

____

Please list any allergies other than drug allergies:

____

____

____

Note for women: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)

FORM RELEASE

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

MULTI-MEDIA RELEASE

I hereby authorize the use, reproduction and publication by Sharkus Hometown Dentistry Website - in any medium - of all forms of media content as indicated by me in this form. I release Sharkus Hometown Dentistry Website, its agents, employees, owners, investors, staff, licensees, and assigns this day from all claims, including but not limited to claims for damages to my reputation, invasion of privacy, right of publicity, copyright infringement or defamation resulting from publication of any media. I wave any right to inspect or approve any media that may be created. I understand that Sharkus Hometown Dentistry Website is and shall be the exclusive owner of all right, title and interest, including copyright in the content and any advertising or promotional materials containing the material released hereunder. This permission and release includes the following: name, voice, visual likeness, photographs, film, videotape or other audiovisual materials.

FEES AND PAYMENT

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorney's fees, and court costs.

NOTICE OF PRIVACY

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: *(Parent or Guardian if minor)* X______________________________ **Date:** X____________________