Welcome To Sharkus Hometown Dentistry

PATIENT INFORMATION

Date_____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.

First Name_____ M.I._____ Last Name_____ Preferred Name_____

Gender: ❑ Male ❑ Female ❑ Non-Binary Birth Date_____ Age_____ Soc. Sec. #_____

E-mail_____

Street_____ City_____ State _____ Zip_____

HomeTel.(_____) _____Cell (_____) _____ Work Tel.(_____)_____

Your Employer_____ Driver's Lic.#_____

Former Dentist_____ Physician_____

Nearest relative not living with you_____ Relationship_____ Tel.(_____)_____

How did you hear about us_____

How would you like notifications of your upcoming appointments: ❑ Email ❑ Text ❑ Phone call

Who will be responsible for your account? *(guarantor information if different from above)*

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other_____

(If self, skip to next section)

Name_____ Relation _____ S.S.#_____ Birth Date_____

Street_____ City_____ State_____ Zip_____

Tel.(____)_____Employer_____ Work Tel.(_____)_____

DENTAL INSURANCE INFORMATION

Do you have dental insurance? ❑ Yes ❑ No

Dental Insurance Company Name _____

Insurance Company Tel. (_____)_____

Primary Insurance Holder Name _____ Birth Date _____

SSN or Member/ID of Policy Holder _____Group # _____

SECONDARY DENTAL INSURANCE

Dental Insurance Company Name _____

Insurance Company Tel. (_____)_____

Secondary Insurance Holder Name _____Birth Date_____

SSN or Member ID of Policy Holder_____Group #_____

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	Y N	Y N	Y N
❑ ❑ ADD/ADHD	❑ ❑ Difficulty Breathing	❑ ❑ Kidney Problems	**For Women:**
❑ ❑ Alzheimer's/Memory Loss	❑ ❑ Drug/Alcohol Abuse	❑ ❑ Liver Disease	❑ ❑ Possibility of pregnancy?
❑ ❑ Anemia	❑ ❑ Emphysema	❑ ❑ Migraines	❑ ❑ Are you nursing?
❑ ❑ Anorexia/Bulimia	❑ ❑ Epilepsy/Seizures	❑ ❑ Pacemaker	❑ ❑ Are you taking birth control pills?
❑ ❑ Arthritis	❑ ❑ Gastrointestinal Disorder	❑ ❑ Previous Biopsies	
❑ ❑ Artificial Joints	❑ ❑ GERD/Acid Reflux	❑ ❑ Recurrent Illnesses	
❑ ❑ Artificial Heart Valves	❑ ❑ Glaucoma (Narrow Angle)	❑ ❑ Rheumatic/Scarlet Fever	
❑ ❑ Asthma	❑ ❑ Hay Fever	❑ ❑ Shingles	
❑ ❑ Behavioral/Mental Disorder	❑ ❑ Headaches (Severe, Frequent)	❑ ❑ Slow-Healing Mouth Sores	Other Conditions (Please List)
❑ ❑ Blood Disorder	❑ ❑ Hearing Impaired	❑ ❑ Smoking Tobacco	_____
❑ ❑ Blood Transfusions	❑ ❑ Heart Attack	❑ ❑ Chewing Tobacco	_____
❑ ❑ Cancer/Chemotherapy	❑ ❑ Heart Disease	❑ ❑ Sinus Problems	_____
❑ ❑ Radiation Treatments	❑ ❑ Heart Murmur	❑ ❑ Stroke	_____
❑ ❑ Cold Sores/Herpes	❑ ❑ Heart Surgery	❑ ❑ Snoring	_____
❑ ❑ Congenital Heart Defect	❑ ❑ Hemophilia/Abnormal Bleeding	❑ ❑ Sleep Apnea	
❑ ❑ COPD	❑ ❑ High or Low Blood Pressure	❑ ❑ Tuberculosis	
❑ ❑ Depression/Anxiety	❑ ❑ Mitral Valve Prolapse	❑ ❑ Thyroid Trouble: ❑Hypo ❑Hyper	
❑ ❑ Diabetes ❑ Type 1 ❑ Type 2	❑ ❑ Hepatitis A B C D	❑ ❑ Tumor Growth	
Recent HbA1c_____	❑ ❑ HIV/AIDS	❑ ❑ Venereal Disease (STD/STI)	

Have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? ❑ Yes ❑ No

If so, when did the treatment begin?_____When did the treatment end?_____

Do you ever faint, 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 and supplements)*

Medications & 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 / Amoxicillin	❑ ❑ Aspirin	❑ ❑ Local anesthetic (numbing med)	❑ ❑ Eggs / Yolk
❑ ❑ Sulfa Drugs	❑ ❑ Codeine or other narcotics	❑ ❑ Sulfites	❑ ❑ Soy
❑ ❑ Valium or other tranquilizers	❑ ❑ Tylenol/Ibuprofen/NSAIDS	❑ ❑ Latex or Metals	❑ ❑ Food Allergy

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.)

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

Last dental exam_____ Last dental x–rays_____ Last dental cleaning_____

Times a day you brush?_____ Times a week you floss?_____

What type of tooth bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? *(worst)* 1 2 3 4 5 6 7 8 9 10 *(best)*

Smile Concerns *(if any)*:

_____

_____

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? ❑ 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?_____

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 authorize my name, photograph, story, audio, and/or video to be used in any number of marketing purposes and communication mediums for Sharkus Hometown Dentistry after expressed consent by myself. I agree to the use, reproduction, and publication by Sharkus Hometown Dentistry in any medium. I understand that I release of all claims, whether legal or equitable, in connection with said publication of any media.

CANCELLATION POLICY

No-show appointments and those appointments not canceled within 24 hours will be charged a fee of $40.00/hour.

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. A late fee of 18% APR will be applied to balances 60 days past due.

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_____