New Patient Information

Welcome to our practice.

Please take your time to fill out this form completely. The more we learn about you, the better personal care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Today's date _____

First name _____ Middle name _____ Last name _____

I prefer to be called (nickname, etc.) _____ ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

Date of birth _____ Age _____ Social security no. _____

Home phone ( ) _____ - _____ Work phone ( ) _____ - _____ Cell phone ( ) _____ - _____

Primary contact number (please check one) ☐ Home ☐ Work ☐ Cell Best time to call _____

Driver's license no. _____ E-mail _____

Do you have a preference for appointment times? ☐ Yes ☐ No When? _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____

Whom may we thank for referring you? _____

_____

Reason for today's visit _____

Are you currently in pain? ☐ Yes ☐ No

If so, please describe: _____

Do you have any dental problems now? ☐ Yes ☐ No

If so, please describe: _____

Have you ever had trouble with a previous dental treatment? ☐ Yes ☐ No

If so, please describe: _____

Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)

Date of last dental exam _____ Date of last cleaning _____ Date of last full mouth X-rays _____

Procedure(s) done at last dentist visit _____

Previous dentist's name _____

Are you changing dentists? ☐ Yes ☐ No Why? _____

How often do you have dental examinations? _____ How often do you brush your teeth? _____

How often do you floss? _____ What type of bristles do you use? ☐ Hard ☐ Medium ☐ Soft

What other dental aids do you use? (Mouth rinse, electric toothbrush, toothpick, etc.) _____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you noticed any mouth odors or bad tastes? ☐ Yes ☐ No

Do you bite your lips or cheeks frequently? ☐ Yes ☐ No

Do you have frequent headaches? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Are your teeth sensitive to heat/cold? ☐ Yes ☐ No

Do you still have your wisdom teeth? ☐ Yes ☐ No

Is there anything else that you want our office to know about you that will help us to serve you better?

_____

_____

_____

We Appreciate Your Referrals.

www.HamiltonDentalAustin.com

New Patient Information

Have you ever had:

Periodontal disease/gum treatment	☐ Yes	☐ No	Discomfort in your jaw joint (TMJ/TMD)	☐ Yes	☐ No
Orthodontics treatment	☐ Yes	☐ No	Your teeth ground or bite adjusted	☐ Yes	☐ No
Oral surgery	☐ Yes	☐ No	Serious injury to the mouth or head	☐ Yes	☐ No
A bite plate or mouth guard	☐ Yes	☐ No			

If yes to any of the previous questions, please describe _____

_____

Is there anything else about your past dental treatment(s) that you would like us to know? _____

_____

Medical History

Have you been hospitalized or under the care of a medical doctor during the past 2 years? ☐ Yes ☐ No

If yes, for what? _____

Hospital or Physician's name _____ Phone _____

Hospital or Physician's city _____ State _____

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines) ☐ Yes ☐ No

If yes, please explain: _____

Have you ever taken Fen-Phen? ☐ Yes ☐ No

If so, how long ago? _____

Have you been to the doctor to check for heart problems? ☐ Yes ☐ No

If so, what are the problems? _____

Do you use tobacco? ☐ Yes ☐ No Do you use alcohol or any other controlled substance? ☐ Yes ☐ No

Bone replacement therapy? Fosamax Boniva Calcimar Evista Actonel Forted Zometa Other _____

Women Only:

Are you pregnant or think you may be pregnant? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Indicate which of the following you have had or have at present:

AIDS/HIV	☐ Yes	☐ No	Difficulty Breathing	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Alcohol/Drug Abuse	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Allergies or Hives	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Nervousness/Anxiety	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Artificial Heart Valve	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Psychological Care	☐ Yes	☐ No	Artificial Bones/Joints	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Hearing Disorder	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart (Surgery, Disease, Attack)	☐ Yes	☐ No	Rheumatic/Scarlet Fever	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble/Snoring/Sleep Apnea	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Cold Sores/Herpes	☐ Yes	☐ No	Hepatitis A B C (circle)	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Hospitalized for any reason	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tuberculosis (TB)	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No	Diet (Special/Restricted)	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No	Venereal Disease/STB	☐ Yes	☐ No			

Please list any serious medical condition(s) that you have ever had not listed above: _____

_____

_____

Are you aware of having any allergic (or adverse) reaction to any of the following:

Aspirin	☐ Yes	☐ No	Iodine	☐ Yes	☐ No	Sedatives	☐ Yes	☐ No
Codeine	☐ Yes	☐ No	Jewelry/Metals	☐ Yes	☐ No	Sulfa Drugs	☐ Yes	☐ No
Anesthetics (i.e. Novocaine)	☐ Yes	☐ No	Latex	☐ Yes	☐ No	Tetracycline	☐ Yes	☐ No
Erythromycin	☐ Yes	☐ No	Penicillin or Other Antibiotics	☐ Yes	☐ No	Other		

Patient signature _____ Date: _____

Clayton M. Hamilton, D.D.S. ★ Trevor Hamilton, D.D.S.
7121 Chimney Corners, Austin, TX 78731
Phone (512) 345-2170 Fax (512) 345-6356

Dental Insurance

Welcome to our practice.

Please take your time to fill out this form completely. The more we learn about you, the better personal care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Primary Carrier

Insurance co. name _____ Insurance co. phone _____

Address (Street, City, State, ZIP) _____

Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____

Insured's name _____ Relationship to patient _____

Date of birth _____ Insured's social security no. _____

Insured's employer name _____ Is insured a patient in our practice? ☐ Yes ☐ No

Secondary Carrier

Insurance co. name _____ Insurance co. phone _____

Address (Street, City, State, ZIP) _____

Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____

Insured's name _____ Relationship to patient _____

Date of birth _____ Insured's social security no. _____

Insured's employer name _____ Is insured a patient in our practice? ☐ Yes ☐ No

Person Financially Responsible for Account

Name _____ Relationship to patient _____

Social security no. _____ Phone ( ) -

Driver's license no. _____ Date of birth _____

Address (Street, City, State, ZIP) _____

Employer _____ Work phone ( ) -

Preferred payment method: ☐ Cash ☐ Credit Card

Visa/MC/AMEX no. _____ Exp. Date _____

If patient is a minor, name of parent or legal guardian and relationship _____

Is this parent or legal guardian currently a patient in our office? ☐ Yes ☐ No

With whom may we discuss your treatment other than your insurance company and Medical/Dental professionals? _____

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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

Please Print Name _____

Signature _____ Date _____

Person to contact in case of emergency

Name _____ Relationship _____

City _____ State _____ Cell Phone _____

Home phone _____ Work Phone _____

OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

_____ Date _____

Health History Update

Today's date _____ Patient Number _____

First name _____ Middle name _____ Last name _____

Address _____ City _____ State _____ Zip _____

Home phone ( )_____-_____ Work phone ( )_____-_____ Cell phone ( )_____-_____

Email _____

Anything else we should know? _____

_____

Health Changes since last vist: _____ Date health change occurred _____

_____

_____

_____

_____

Physician's Name _____ Physician's Phone _____

Current Medications:

_____

_____

_____

_____

Last physical exam _____ Any Allergies _____

Patient Signature _____ Staff initials _____ Date _____

Health Changes since last vist: _____ Date health change occurred _____

_____

_____

_____

_____

Physician's Name _____ Physician's Phone _____

Current Medications

_____

_____

_____

_____

Last physical exam _____ Any Allergies _____

Patient Signature _____ Staff initials _____ Date _____

Health Changes since last vist: _____ Date health change occurred _____

_____

_____

_____

_____

Physician's Name _____ Physician's Phone _____

Current Medications

_____

_____

_____

_____

Last physical exam _____ Any Allergies _____

Patient Signature _____ Staff initials _____ Date _____