

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? _____

Preferred Pharmacy _____

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 you have frequent headaches? Yes No

Do your gums ever bleed? Yes No

Do you clench or grind your teeth? Yes No

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

Are your teeth sensitive to heat/cold? Yes No

Do you bite your lips or cheeks frequently? 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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Discomfort in your jaw joint (TMJ/TMD) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Orthodontics treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Your teeth ground or bite adjusted | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Oral surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Serious injury to the mouth or head | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| A bite plate or mouth guard | <input type="checkbox"/> Yes <input type="checkbox"/> 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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty Breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lupus | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcohol/Drug Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies or Hives | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervousness/Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or Dizzy Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychological Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Bones/Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hearing Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart (Surgery, Disease, Attack) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic/Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble/Snoring/Sleep Apnea | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cold Sores/Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A B C (circle) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hospitalized for any reason | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis (TB) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diet (Special/Restricted) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease/STB | <input type="checkbox"/> Yes <input type="checkbox"/> 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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Iodine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sedatives | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Codeine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jewelry/Metals | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sulfa Drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anesthetics (i.e. Novocaine) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tetracycline | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Erythromycin | <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin or Other Antibiotics | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other | _____ |

Patient signature _____ Date: _____

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 Dental 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 Dental 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 _____

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Current Medications

Last physical exam _____ Any Allergies _____

Patient Signature _____ Staff initials _____ Date _____