

DWAYNE HALL DENTISTRY

Patient Information

Date: _____

Patient Information

First Name: _____ Last Name: _____ Preferred Name: _____

DOB: _____ Age: _____ Male ___ Female ___ Married ___ Single ___ Child ___ SS#: _____

Phone Numbers:

Home: _____ Work: _____ Cell: _____ **E-mail:** _____

Address:

Street: _____ City: _____ St: _____ Zip: _____

Responsible Party/Parent Information (if different than above)

First Name: _____ Last Name: _____ DOB: _____ Age: _____

Relationship: Mother ___ Father ___ Other: _____ (please specify) SS#: _____

Phone Numbers:

Home: _____ Work: _____ Cell: _____ E-mail: _____

Address:

Street: _____ City: _____ St: _____ Zip: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Whom May We Thank For Referring You To Our Office? : _____

Employment Information:

Employer: _____ Employer Address: _____

Employer Phone: _____ Occupation: _____ Yrs. Employed: _____

Insurance Information:

Subscriber's Name: _____ DOB: _____

Subscriber's SS#: _____ Subscriber's ID: _____ Group #: _____

Subscriber's Employer: _____ Relationship to Insured: _____

Insurance Co Name: _____ Phone: _____

Address: _____ City: _____ St: _____ Zip: _____

Secondary Insurance Information:

Subscriber's Name: _____ DOB: _____

Subscriber's SS#: _____ Subscriber's ID: _____ Group #: _____

Subscriber's Employer: _____ Relationship to Insured: _____

Insurance Co Name: _____ Phone: _____

Address: _____ City: _____ St: _____ Zip: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any changes in my health or medication.

Signature _____ Date: _____

(If minor, Parent/Guardian Signature)

Dental /Medical History

Patient's Name: _____ Birth Date: _____ Age: _____

Your Physician's Name: _____ Phone # _____ Last Visit Date: _____

Are you taking any medication now, including regular dosages of aspirin, over the counter & prescription? Yes ___ No ___

If so, please list name and dosage:

Are you, or have you ever, taken biophosphonates; drugs that prevent the loss of bone mass, used to treat osteoporosis?

Yes ___ No ___ If yes, which one? Fosamax ___ Boniva ___ Actenol ___ Aredia ___ Other (list) _____

Are you aware of having an allergic reaction to any medication or substance? Yes ___ No ___

Codeine ___ Sulfa ___ Penicillin ___ Anesthetics ___ Other (please explain) _____

Please explain reaction: _____

Have you been under the care of a medical doctor during the past two years? Yes ___ No ___

If yes, explain? _____

Have you seen an ENT (ear, nose and throat doctor)? Yes ___ No ___ Dr's Name _____

Have you seen a chiropractor? Yes ___ No ___ Dr.'s name _____

Have you seen a neurologist? Yes ___ No ___ Dr.'s name _____

Have you had braces? Yes ___ No ___ Dr.'s name _____

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart Concerns	Yes	No	Headaches	Yes	No	Sickle Cell Disease	Yes	No
Congenital Heart Disease	Yes	No	Jaw Pain	Yes	No	Neurological Disorders	Yes	No
Heart Murmur	Yes	No	Jaw Popping	Yes	No	Tingling in arms/fingers	Yes	No
High blood pressure	Yes	No	Limited Opening	Yes	No	Insomnia/frequent waking	Yes	No
Mitral Valve Prolapse	Yes	No	Congested Ears	Yes	No	Have you ever been treated for periodontal (gum) disease?	Yes	No
Artificial Heart Valve	Yes	No	Dizziness	Yes	No		Does food pack or catch between your teeth?	Yes
Pacemaker	Yes	No	Ringling Ears	Yes	No	Do your gums bleed?	Yes	No
Stroke	Yes	No	Posture Problems	Yes	No	Does your breath concern you?	Yes	No
Asthma	Yes	No	Loose Teeth	Yes	No		Doctor Signature: _____	
Liver Disease/Jaundice	Yes	No	Clenching	Yes	No	Date: _____		
Latex Sensitivity	Yes	No	Grinding	Yes	No	BP _____ / _____ P _____		
Artificial Joints	Yes	No	Facial Pain	Yes	No			
Kidney Trouble	Yes	No	Sensitive Teeth	Yes	No			
Radiation/Chemotherapy	Yes	No	Neck Ache	Yes	No			
Epilepsy/Seizures	Yes	No	Bell's Palsy	Yes	No			
Diabetes	Yes	No	Difficulty Chewing	Yes	No			
Hepatitis	Yes	No	Difficulty Swallowing	Yes	No			
AIDS/HIV	Yes	No	Trigeminal Neuralgia	Yes	No			

Do you have or have you had any disease, condition or problem that we should be aware of? Yes ___ No ___

If yes, please explain: _____

Do you have any question for the doctor or hygienist today? _____

Patient's Name: _____ Signature: _____

Name of Parent/Guardian: _____ Signature: _____