

Hurstbourne

Dental Care

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Welcome

Patient Information (CONFIDENTIAL)

Name _____ Home Phone _____ Patient # _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

E-Mail _____ Birthdate _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If Student, Name of School / College _____ City _____ State/Prov. _____ Full Time Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? How Did You Find HS?

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party (Not Living with You)

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

E-Mail _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS #/SIN _____

Is this Person Currently a Patient in our Office? Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS #/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS #/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	9. Are you allergic to or have you had any reactions to the following?			Yes	No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	<input type="checkbox"/>		<input type="checkbox"/>		Local Anesthetics (e.g. Novocain)	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain _____					Penicillin or other Antibiotics	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medicine?	<input type="checkbox"/>		<input type="checkbox"/>		Sulfa Drugs	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medication(s) are you taking? _____					Barbiturates	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever taken Fen-Phen/Redux?	<input type="checkbox"/>		<input type="checkbox"/>		Sedatives	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use tobacco?	<input type="checkbox"/>		<input type="checkbox"/>		Iodine	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
6. Do you use controlled substances?	<input type="checkbox"/>		<input type="checkbox"/>		Aspirin	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
7. Are you wearing contact lenses?	<input type="checkbox"/>		<input type="checkbox"/>		Any Metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
					Latex Rubber	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have or have you had any of the following?					Other (please list) _____	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>		<input type="checkbox"/>		11. Women Only:				
Rheumatic Fever	<input type="checkbox"/>		<input type="checkbox"/>		a) Are you pregnant or think you may be pregnant?	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>		<input type="checkbox"/>		b) Are you nursing?	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures	<input type="checkbox"/>		<input type="checkbox"/>		c) Are you taking oral contraceptives?	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>		<input type="checkbox"/>						
Low Blood Pressure	<input type="checkbox"/>		<input type="checkbox"/>		Chest Pains	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions	<input type="checkbox"/>		<input type="checkbox"/>		Easily Winded	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>		<input type="checkbox"/>		Stroke	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>		<input type="checkbox"/>		Hay Fever / Allergies	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>		<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>		<input type="checkbox"/>		Radiation Therapy	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>		<input type="checkbox"/>		Glaucoma	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
					Recent Weight Loss	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
					Liver Disease	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
					Heart Trouble	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
					Respiratory Problems	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
					Mitral Valve Prolapse	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
					Other _____	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	8. Do you have frequent headaches?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
2. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>		<input type="checkbox"/>		9. Do you clench or grind your teeth?	<input type="checkbox"/>		<input type="checkbox"/>	
3. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>		<input type="checkbox"/>		10. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>		<input type="checkbox"/>	
4. Do you feel pain to any of your teeth?	<input type="checkbox"/>		<input type="checkbox"/>		11. Have you ever had any difficult extractions in the past?	<input type="checkbox"/>		<input type="checkbox"/>	
5. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>		<input type="checkbox"/>		12. Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>		<input type="checkbox"/>	
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>		<input type="checkbox"/>		13. Have you had any orthodontic treatment?	<input type="checkbox"/>		<input type="checkbox"/>	
7. Have you ever experienced any of the following problems in your jaw?					14. Do you wear dentures or partials?	<input type="checkbox"/>		<input type="checkbox"/>	
Clicking?	<input type="checkbox"/>		<input type="checkbox"/>		If yes, date of placement _____				
Pain (joint, ear, side of face)?	<input type="checkbox"/>		<input type="checkbox"/>		15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>		<input type="checkbox"/>	
Difficulty in opening or closing?	<input type="checkbox"/>		<input type="checkbox"/>		16. Do you like your smile?	<input type="checkbox"/>		<input type="checkbox"/>	
Difficulty in chewing?	<input type="checkbox"/>		<input type="checkbox"/>						

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X
Signature of patient (or parent if minor) _____

Doctor's Comments _____
Signature _____ Date _____



Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

THE PATIENT ABOVE AUTHORIZES HURSTBOURNE DENTAL CARE TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to **Hurstbourne Dental Care** to use my address, phone number, e-mail address and clinical records to contact me to confirm appointments, remind me about check-ups, and to send birthday/holiday related cards.

- I give **Hurstbourne Dental Care** permission to leave a message about my appointment on my answering machine.

- By signing this form you are giving **Hurstbourne Dental Care** permission to use and disclose your protected health information in accordance with the directives listed above.

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

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

