Dr. David J. Hall, Jr.

802 Timber Dr. • Garner, NC 27529
919-773-2266

**** We do not file Insurance, but will be glad to print you an acceptable insurance receipt to file, if you bring your insurance card.**

PATIENT INFORMATION – (Confidential)

Date: _____

Patient's Name: _____

Birthdate: _____ SS# _____

Address: _____ City: _____State _____ Zip _____

Home # _____ Work # _____ Cell# _____

Male _____ Female _____ Single ____ Married _____ Divorced _____ Widowed _____

Email address: _____

Employer _____

Whom may we thank for referring you? _____

Person to contact in case of emergency? _____

Home # _____ Cell # _____ Work# _____

RESPONSIBLE PARTY (Payment is due at the time of your appointment.)

Name of person responsible for paying this account _____

Relationship to Patient _____

SS # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Employer _____

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No

Please circle if you have or have had any of the following

MOUTH		TEETH	
Bleeding, sore gums	Unpleasant taste/bad breath	Loose teeth	Sensitive to hot or cold
Burning tongue/lips	Frequent Blister lip/mouth	Sensitive to sweets	Sensitive to biting
Swelling/lumps in mouth	Ortho Treatments (braces)	Food impaction	Clinching/grinding
Biting Cheeks/lips	Shifting or change in bite		
Clicking/popping jaw	Difficulty opening or closing jaw		

OVER PLEASE

HEALTH HISTORY

Are you having any pain or discomfort at this time? _____

Do you feel very nervous about having dental treatment? _____

Have you ever had a bad experience in the dental office? _____

Date of last dental visit _____

Have you been under the care of a medical doctor during the past two years? _____

Physician's Name and phone number _____

List all medications and drugs with dosages you are currently taking: _____

_____

_____

_____

_____

Are you allergic or have you reacted adversely to any of the following medications?

Aspirin	Nitrous Oxide	Valium	Penicillin	Latex Gloves	Percodan
Codeine	Erythromycin	Darvon	Scopolamine	Demerol	
Sleeping Pills	Tetracycline	Local Anesthetics	Nembutal/Seconal		Other Antibiotics

Other: _____

Circle any of the following which you have had or have at present

AIDS/HIV positive	Cortisone Medication	Heart Surgery	Renal Dialysis
Alzheimer's	Diabetes	Hemophilia	Rheumatic Fever
Anaphylaxis	Drug Addiction	Hepatitis A	Rheumatism
Anemia/Bruise Easily	Excessive Bleeding	Hepatitis B or C	Scarlet Fever
Angina Pectoris	Emphysema	High Blood Pressure	Seasonal Allergies
Arthritis/Gout	Epilepsy or Seizures	Hives or Rash	Shingles
Artificial Heart Valve	Fainting Spells/Dizziness	Hypoglycemia	Sinus Trouble
Artificial Joint	Frequent Cough	Irregular Heartbeat	Spina Bifida
Asthma	Frequent Headaches	Kidney Problems	Stroke
Blood Transfusion	Glaucoma	Liver Disease	Thyroid Disease
Breathing Problems	Hay Fever	Lung Disease	Tuberculosis
Cancer	Heart Attack/Failure	Osteoporosis	Tumors or Growths
Chemotherapy	Heart Murmur	Pain in Jaw Joints	Venereal Disease
Cold Sores/Fever Blisters	Heart Pacemaker	Psychiatric Care	Yellow Jaundice
Congenital Heart Lesions	Heart Disease	Radiation Treatment	

Have you ever had any serious illness not listed above? Yes No If yes _____

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 records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and or/health practitioners. Payment for dental services is due on the day of your scheduled appointment. If you have dental insurance we will request the insurance company to pay you directly. Therefore, I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient or parent/guardian if minor