Hancock Dental

Quality Gentle Care

ANNUAL UPDATE FORM

In order to serve you properly we will need the following information. PLEASE PRINT.

Patient Information

Name: _____
(First) (MI) (Last) (Preferred Name)

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Contact Number: _____ ☐Email ☐Phone ☐Text

Check Box: ☐Single ☐Married ☐Other ☐Child Spouse or Parent/Guardian Name: _____

Patient or Parent's Employer: _____ Occupation: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Person Responsible for Account

Name of person responsible for this account: _____ Relation: _____

Billing Address (if different from above): _____ City: _____ State: _____ Zip: _____

Insurance Information Primary insurance carrier: _____ ID#: _____

Authorization to Release Information

Hancock Dental is authorized to discuss my dental care, appointments, and/or may release my confidential health information to the following:

Name: _____ Relationship: _____

Informed Consent and Acknowledgement

I consent to allow photographs and/or x-rays to be used for demonstrations, marketing material, patient education, etc. Full Face/Mouth ☐ Teeth/Jaw area only ☐ I refuse to share. _____ (initial) ☐

I understand that I am financially responsible for all charges whether paid by my insurance or not. I authorize the use of my signature on all insurance submissions.

I have answered all questions regarding myself, or my dependent's medical history and present health condition fully and truthfully, including allergies. I also understand if there are any changes in my, or my dependent's health I am to inform the doctor at my next appointment.

I agree to provide a minimum of 24-hour notice if I need to change my appointment for any reason. I understand if I fail an appointment, I may be charged a fee. Failure to show for a second appointment may result in dismissal from the practice.

I instruct the dentist to deliver care that, in their professional judgement, is necessary in the restoration of my health once they've been discovered and discussed.

_____ _____

Patient signature: (or guardian if patient is under 18 years old) Date:

Medical History

Name of Phsician/ and their specialty? _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have or have you ever had:

Yes No

1. Hospitalization for illness or injury_____ ☐ ☐
2. An allergic or bad reaction to any of the following:
   - Asprin, ibuprofen, acetaminophen, codine
   - Penicillin
   - Erythromycin
   - Tetracycline
   - Sulfa
   - Local anesthetic
   - Fluoride
   - Chlorhexidine (CHX)
   - Iodine
   - Metals (nickle, gold, silver)
   - Latex
   - Nuts
   - Fruit
   - Milk
   - Red dye
   - Other
3. Heart problems, or cardiac stent within the last 6 mo ☐ ☐
4. History of infective endocarditis _____ ☐ ☐
5. Artificial heart valve, repaired heart defect (PFO) ☐ ☐
6. Pacemaker or implantable defibrillator_____ ☐ ☐
7. Orthopedic or soft tissure implant (e.g joint replacement, breast implant) _____ ☐ ☐
8. Heart mumur, rheumatic or scarlet fever _____ ☐ ☐
9. High or low blood pressure _____ ☐ ☐
10. A stroke (taking blood thinners) _____ ☐ ☐
11. Anemia or other blood disorder _____ ☐ ☐
12. Prolonged bleeding due to a slight cut (or INR > 3.5) _____ ☐ ☐
13. Pneumonia, emphysema, shortness of breath, sarcoidosis_____ ☐ ☐
14. Chronic ear infections, tuberculosis, measles, chicken pox_____ ☐ ☐
15. Breathing problems (e.g asthma, stuffy nose, sinus congestion) _____ ☐ ☐
16. Sleep problems (e.g sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____ ☐ ☐
17. Kidney disease _____ ☐ ☐
18. Liver disease or jaundice _____ ☐ ☐
19. Vertigo (e.g "the room is spinning) _____ ☐ ☐
20. Thyroid, parathyroid disease, calcium deficiency ☐ ☐
21. Hormone deficiency or imbalance (e.g poly cistic ovarian syndrome) _____ ☐ ☐
22. High cholesterol or taking statin drugs _____ ☐ ☐
23. Diabetes (HbA1c =_____) _____ ☐ ☐
24. Stomach or duodenal ulcer _____ ☐ ☐
25. Digestive or eating disorders (e.g cliac disease, gastric reflux, bulimia, anorexia) _____ ☐ ☐
26. Osetoporosis/osteopenia or ever taken anti-resorptive medications (bisphosphonates) ☐ ☐
27. Arthritis or gout _____ ☐ ☐
28. Autoimmune disease (e.g rheumatoid arthritis, lupus, scleroderma) _____ ☐ ☐
29. Glaucoma _____ ☐ ☐
30. Contact lenses _____ ☐ ☐
31. Head or neck injuries _____ ☐ ☐
32. Epilepsy, convulsons (seizures) _____ ☐ ☐
33. Neurologic disorders (e.g alzheimer's disease, dementia, prion disease) _____ ☐ ☐
34. Viral infections and cold sores _____ ☐ ☐
35. Any lumps or swelling in the mouth_____ ☐ ☐
36. Hives, skin rash, hay fever_____ ☐ ☐
37. STI/STD/HPV_____ ☐ ☐
38. Hepatitis (type____) _____ ☐ ☐
39. HIV/AIDS _____ ☐ ☐
40. Tumor, abnormal growth _____ ☐ ☐
41. Radiation therapy _____ ☐ ☐
42. Chemotherapy, immunosuppressive meds__ ☐ ☐
43. Emotional difficulties _____ ☐ ☐
44. Psychiatric treatment or antidepressant medication_____ ☐ ☐
45. Concentration problems or ADD/ADHD _____ ☐ ☐
46. Alcohol/recreational drug use _____ ☐ ☐

Are you:

47. Presently being treated for any other illness ☐ ☐
48. Aware of a change in your health in the last 24 hours (fever, chills, new cough, diarrhea) ☐ ☐
49. Taking medications for weight management ☐ ☐
50. Taking dietary supplements, vitamins, and/or probiotics_____ ☐ ☐
51. Often exhausted or fatigued_____ ☐ ☐
52. Experiencing headaches or chronic pain____ ☐ ☐
53. A smoker, smoked previously or other (smokeless tobacco, vaping, e-cig, cannabis) ☐ ☐
54. Considered a touchy/sensitive person _____ ☐ ☐
55. Often unhappy or depressed _____ ☐ ☐
56. Taking birth control pills _____ ☐ ☐
57. Currently pregnant _____ ☐ ☐
58. Diagnosed with a prostate disorder _____ ☐ ☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment _____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years _____

_____

Patients signature _____ Date_____