Hancock Dental

Hancock Dental
Gentle Quality Care

WELCOME

Thank you for choosing our office for your continuing dental care. In order to serve you properly we will need the following information. All information is protected by the patient-doctor confidentiality. PLEASE PRINT.

Patient Information

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

Address: ____________________ City: ______________ State: _____ Zip: ________

Birthdate: ______________ SSN: ______________ Email: ____________________

Cell Phone: ______________ Home Phone: ______________ Work Phone: ______________

Check Appropriate Box: ☐Male ☐Female ☐Unspecified ☐Single ☐Married ☐Other ☐Child

Patient or Parent's Employer: ____________________ Occupation: ______________

Parent/Guardian Name: ______________ Preferred way of contact: (circle one) *text email phone*

Emergency Contact: ______________ Relation: __________ Phone: ______________

How did you hear about our office? Friend: __________ Internet: ________ Other: ________

Person Responsible for Account

Name of person responsible for this account: ____________________ Relation: __________

Insurance Information Policy holder's name: ______________ Relationship to patient: __________

Birthdate: __________ SSN: ______________ Insurance Company: ____________________

Name of employer: ____________________ Do you have any additional insurance? ☐Yes ☐No

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 the use of photographs and x-rays 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 health, I am to inform the doctor.

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.

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.

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a Notice of Privacy Practices. Our notice is available online. If you prefer a paper copy, please ask a team member for a copy of our Notice.

I acknowledge that a copy of the office's Notice of Privacy Practices has been made available to me.

______________________________ ______________________
Patient signature: (or guardian if patient is under 18) 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____________________

Dental History

How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous dentist_________________ Date of last dental exam __/__/____ Date of most recent Xrays __/__/____

I routinely see my dentist every ☐ 3 mo. ☐4 mo. ☐6 mo. ☐12 mo. ☐ Not routinely

Personal History ☐ ☐ ☐ — Yes No

1. Are you fearful of dental treatment? How fearful, on a scale of 1(Least) to 10 (most) [___]____________________ ☐ ☐
2. Have you had an unfavorable dental experience? ____________________ ☐ ☐
3. Have you ever had complications from past dental treatment? ____________________ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ____________________ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? ____________________ ☐ ☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trama? _____ ☐ ☐

Gum and Bone ☐ ☐ ☐ — Yes No

7. Do your gums bleed sometimes or are they ever painful when brushing or flossing? ____________________ ☐ ☐
8. Have you ever been treated for gum disease, had scaling and root planing, or been told you lost bone around your teeth? ☐ ☐
9. Have you ever noticed an unpleasent taste or odor in your mouth? ____________________ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family ____________________ ☐ ☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? ____________________ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? ____________________ ☐ ☐

Tooth Structure ☐ ☐ ☐ — Yes No

14. Have you had any cavities within the past 3 years? ____________________ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ____________ ☐ ☐
16. Do you feel or notice any holes (i.e pitting, craters) on the biting surface of your teeth? ____________________ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth ____________ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? ____________________ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ____________________ ☐ ☐
20. Do you frequently get food caught between any teeth? ____________________ ☐ ☐

Bite and Jaw Joint ☐ ☐ ☐ — Yes No

21. Do you have problems with your jaw joint? (Pain, sounds, limited opening, locking, popping) ____________________ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? ____________ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? __________ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? ____________________ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? ____________________ ☐ ☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? ____________________ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? ____________________ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ____________________ ☐ ☐
30. Do you clench or grind your teeth together in the daytime or make them sore? ____________________ ☐ ☐
31. Do you have any problems with sleep (i.e restlessness or teeth grinding) wake up with a headache or an awareness of your teeth? ☐ ☐
32. Do you wear or have you ever worn a bite appliance? ____________________ ☐ ☐

Smile Characteristics ☐ ☐ ☐ — Yes No

33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (Shape, color, size, display) ____________________ ☐ ☐
34. Have you ever bleached (whitened) your teeth? ____________________ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? ____________________ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? ____________________ ☐ ☐