HOMETOWN FAMILY DENTAL

CREATING SMILES WITH A PERSONAL TOUCH

PATIENT INFORMATION

Patient's Name: _____Preferred Name: _____Date of Birth___/___/____
Street Address: _____City: _____State:____ Zip:_____
Home Phone:_____ Cell Phone:_____ SSN#: _____
Sex: AFS Male AFS Female Marital Status: Single Married Divorced Widowed Dental Insurance: Yes AFS No

RESPONSIBLE PARTY INFORMATION

Name: _____ Relation to patient:_____
Employer:_____ Work #:_____ Mobile #:_____Date of Birth ___/___/____
SSN#: _____

DENTAL INSURANCE INFORMATION

Primary Ins. Subscriber: _____ Date of Birth ___/___/____ SSN#: _____
Relation to patient:_____ Work #:_____ Mobile #:_____
Primary Insurance Company: _____Group Number: _____

Secondary Ins. Subscriber: _____ Date of Birth ___/___/____ SSN#: _____
Relation to patient:_____ Work #:_____ Mobile #:_____
Secondary Insurance Company: _____Group Number: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____
Home Phone: _____Work Phone: _____ Mobile: _____

HEALTH PROVIDER INFORMATION

Physician: _____ Phone#: _____
Mailing Address: _____ City: _____ State:_____ Zip: _____
Preferred Pharmacy:_____

DENTAL HISTORY

What is the reason for today's dental visit?_____

□ Yes □ No Have you ever been to the dentist? Date of last cleaning & x-rays (if taken)_____
Name of previous dentist: _____Phone: _____

□ Yes □ No Have you experienced any unfavorable reaction from previous dental care?
Explain _____

On a scale of 1 to 10, please rate how you feel about your teeth and smile with 1 meaning you dislike your smile and 10 meaning you love your smile? Please list your number and a brief explanation of why you choose it below?

_____

Please check if you are having problems with any of the following:

□ Cavities □ Toothache □ Sensitive Teeth □ Mouth Breathing
□ Trauma □ Gum Infections □ Color of Teeth □ Other
□ Orthodontics □ Jaw Sounds □ Grinding of Teeth
Comments: _____

MEDICAL HISTORY

□ Yes □ No Are you in good health? Date of last physical exam _____

□ Yes □ No Are you currently being treated by a doctor for a health problem?
_____

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□ Yes □ No Have you ever been hospitalized, had general anesthesia, or had any surgeries? Please explain: _____

□ Yes □ No Do you know of any existing allergies? If so, please list the allergen and reaction (hives, itchy, swelling, etc): _____

□ Yes □ No Are you currently taking any medications? Please give medication, dose, and reason: _____ _____

□ Yes □ No Have you ever been told that you need to take *antibiotics before dental treatment*? _____

Please check if you are currently or have been treated for any of the following:

□ Heart (Attack, Murmur, Surgery)	□ Diet Restrictions/Special Diet	□ Hay Fever/ Seasonal Allergies	□ Hepatitis A, B, or C
□ Chest Pain	□ Artificial Joints (Knees, Hips, etc.)	□ Latex sensitivity/Allergy	□ Venereal Disease
□ Congenital Heart Disease	□ Kidney Trouble	□ Allergies/ Hives	□ AIDS/HIV
□ High Blood Pressure	□ Ulcers, Gastric Reflux	□ Sinus Trouble	□ Blood Transfusion
□ Mitral Valve Prolapse	□ Diabetes	□ Radiation Therapy	□ Hemophilia
□ Artificial Heart Valve	□ Thyroid Problems	□ Chemotherapy	□ Sickle Cell Disease
□ Rheumatic Fever	□ Glaucoma	□ Tumors/Cancer	□ Bruise Easily
□ Arthritis	□ Tuberculosis	□ Recurrent headaches	□ Liver Disease
□ Cortisone Medications (Steroids)	□ Asthma	□ Recurrent herpes/fever blisters**	□ Yellow Jaundice
□ Stroke	□ Neurological Disorder	□ Epilepsy or Seizures	□ Fainting or Dizzy Spells
□ Anxiety or Depression			

Please note that if you have an **active herpes lip lesion on the day of your scheduled appointment, we may ask you to reschedule depending on the proposed treatment.

For Women only: Are you pregnant? Y N If yes, Due Date: _____ Are you currently breastfeeding? Y N
Are you taking birth any form of birth control (shots, pills, patch, etc.)? Y N

Please list any conditions not mentioned above:

_____

_____

CONSENT FOR DENTAL TREATMENT

I do hereby request and authorize Dr. Molly Mullen and her staff to examine, clean, and provide dental treatment on myself. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Mullen to diagnose and/or treat my dental problem (s). The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

I understand I will be responsible for any charges incurred for my for dental treatment. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Hometown Family Dental of any changes in my medical status.

Patient Name (printed): _____ Date:_____

Patient Signature: _____

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