PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Today's Date:_____

Patient's Name: _____ Preferred Name: _____
Birth Date:_____ Sex:_____ Age:_____ Social Security#:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Mailing Address: _____ City:_____ State:_____ Zip:_____
E-Mail Address:_____
❑ Minor (name of guardian:_____) ❑ Single ❑ Married ❑ Divorced ❑Widowed ❑ Separated ❑ Other
Employer/School:_____ Occupation:_____
Spouse's Name:_____ Spouse's Employer:_____ Spouse's Phone:_____
Whom may we thank for referring you to our office? _____

INSURANCE AND BILLING INFORMATION: ❑ Not covered by dental insurance

Who is responsible for this account?_____ Social Security #:_____
Relationship to patient:_____ Address (if different than patient):_____
Primary Dental Insurance Company:_____ Subscriber Name:_____
Subscriber DOB:_____ Relationship to Patient:_____
Subscriber ID#:_____ Group#:_____ Group Name:_____
Insurance Co. Address:_____ Ins. Phone:_____
Secondary Dental Insurance Company:_____ Subscriber Name:_____
Subscriber DOB:_____ Relationship to Patient:_____
Subscriber ID#:_____ Group#:_____Group Name:_____
Insurance Co. Address:_____ Ins. Phone:_____

EMERGENCY CONTACT:

Person to contact:_____ Relationship:_____
Phone:_____
❑ I give permission for Hiram Dentistry to share my dental and account information with:_____
❑ I give permission for Hiram Dentistry to text and/or email my dental appointments or dental information.

Initials:_____

DENTAL HEALTH HISTORY

Reason for today's visit:_____
Former Dentist:_____
City/State:_____
Date of last dental visit:_____

Do you have or have you had any of the following?
(Please check any that apply)

❑ Bad breath
❑ Bleeding gums
brush?_____
❑ Blisters on lips or mouth
❑ Burning sensation on tongue
❑ Chew on one side of mouth
❑ Cigarette, pipe, or cigar smoking
❑ Clicking or popping jaw
❑ Dry mouth
❑ Fingernail biting
❑ Food collection between teeth
❑ Foreign objects
❑ Grinding teeth
❑ Gums swollen or tender
❑ Jaw pain or tiredness
❑ Lip or cheek biting
❑ Loose teeth or broken fillings
❑ Mouth breathing
❑ Mouth pain, brushing
❑ Orthodontic treatment
❑ Pain around ear
❑ Periodontal treatment
❑ Sensitivity to cold
❑ Sensitivity to heat
❑ Sensitivity to sweets
❑ Sensitivity when biting
❑ Sores/growth in mouth
❑ Chew tobacco
How often do you floss?_____
_____
How often do you
_____

MEDICAL HEALTH HISTORY

Physician's Name:_____ Date of last visit:_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) or Redux (dexfenfluramine). ❑ Yes ❑ No

Do you have or have you had any of the following? (Please check any that apply)

❑ AIDS/HIV
❑ Anemia
❑ Arthritis, Rheumatism
❑ Artificial Heart Valves
❑ Artificial joints
❑ Asthma
❑ Back problems
❑ Bleeding abnormally w/ Extractions or surgery
❑ Blood disease
❑ Cancer
❑ Chemical Dependency
❑ Chemotherapy
❑ Circulatory problems
❑ Congenital heart lesions
❑ Cortisone treatments
❑ Cough, persistent or bloody
❑ Diabetes
❑ Emphysema
❑ Epilepsy
❑ Fainting or dizziness
❑ Glaucoma
❑ Headaches
❑ Heart murmur
❑ Heart problems
❑ Hepatitis Type _____
❑ Herpes
❑ High blood pressure
❑ Jaundice
❑ Jaw pain
❑ Kidney disease
❑ Liver disease
❑ Low blood pressure
❑ Mitral valve prolapse
❑ Nervous problems
❑ Pacemaker
❑ Psychiatric care
❑ Radiation treatment
❑ Respiratory disease
❑ Rheumatic fever
❑ Scarlet fever
❑ Shortness of breath
❑ Sinus trouble
❑ Skin rash
❑ Special diet
❑ Stroke
❑ Swollen feet or ankles
❑ Swollen neck glands
❑ Thyroid problems
❑ Tonsillitis
❑ Tuberculosis
❑ Tumor or growth on head or neck
❑ Ulcer
❑ Venereal disease
❑ Weight loss, unexplained

Do you wear contact lenses? ❑ Yes ❑ No

List any medications you are currently taking and the correlating diagnosis:_____

_____

Pharmacy Name:_____ Phone:_____

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

❑ Aspirin
❑ Iodine
❑ Penicillin or other antibiotics
❑ Barbiturates, sedatives, or sleeping pills
❑ Latex materials
❑ Sulfa drugs
❑ Codeine or other narcotics
❑ Local anesthetics ("Novocain")
❑ Other:_____

The following questions relate to the need for antibiotic prophylaxis to prevent a potentially serious infection:

Have you ever been advised to premed (take an antibiotic) before dental appointments? ❑ Yes ❑ No

● Mitral Valve Prolapse
● Artificial joints
●Heart murmur
●Artificial heart valves
●Rheumatic fever
●Previous bacterial endocarditis

If you have had any of the above conditions, but you know that you are not required to premedicate, we will require a letter from your physician indicating that you do not need to premedicate.

Women:

Are you pregnant? ❑ Yes ❑ No Due date:_____ Are you nursing? ❑ Yes ❑ No

Taking birth control pills? ❑ Yes ❑ No

Please list anything else we should know about your medical history:_____

Consent for Treatment:

I certify that I have read and understand the above information to the best of my knowledge and that I, and/or my dependents have insurance coverage through the above carrier. The above questions have been accurately answered. I understand that providing the incorrect information can be dangerous to my health. I hereby authorize Hiram Dentistry to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I understand there are certain risks inherent in dental treatment; such as but not limited to: pupal sensitivity or damage, tissue swelling or bruising, soreness of jaws, paresthesia and other procedure specific risks. I will not hold Dr. Vu / Hiram Dentistry responsible for the results of any errors or omissions in the information I have provided on this form.

Insurance Release: I authorize release of information regarding my dental treatment to my insurance carrier. I agree to be responsible for payment on services rendered during my ineligible insurance period and any balance not paid by the insurance carrier. I understand that insurances are billed as a courtesy and that I am ultimately responsible for all costs of treatment.

Signature:_____ Date:_____

Print Name:_____