

Patient Name:	Preferred Name:					
Birth date:	Social Security #:					
Address:						
City:	State:	2	Zip:			
Mailing Address (if different): _						
Phone: (H)	(W)		(C)			
Email:	Married		Single $\square$	Divorced □	Widowed	
May we email / text you about:	Appointments?	Yes	No			
	Special Offers?	Yes	No			
	Dental Information?	Yes	No			
Name of Employer:						
Primary Dental Insurance Com	pany:					
Subscriber Name:	Subscriber l	Numbe	er or SSN:			
Secondary Dental Insurance Co.	mpany:					
Subscriber Name:	Subscriber Nu	ımber (	or SSN:			
Emergency Contact Person:		Rel	ationship:			
Phone Number:						
How did you hear about our	office?					



Cancer/Leukemia YES NO Heart Pacemaker YES NO Sickle Cell Disease YES NO Chemotherapy/Radiation YES NO Hemophilia/Bleeding issues YES NO Sinus Trouble YES NO	(Next two question	ons for E	Existin	g Patients Only)					
MEDICAL HISTORY	Change in Address	S		YES	NO _				_
MEDICAL HISTORY  Do you currently have, or have you ever had any of the following:  Alcheimer's/Dementia YES NO Epilepsy or Seizures YES NO Loud Snoring YES NO Anthritis YES NO Epilepsy or Seizures YES NO Loud Snoring YES NO Anthritis YES NO Frequent Cold Sories YES NO Loud Snoring YES NO Anthritis YES NO Frequent Cold Sories YES NO Multiple Sciencesis YES NO Antificial Heart Valve YES NO Frequent Cold Sories YES NO Multiple Sciencesis YES NO Asthma YES NO Heart Detect-Heart Murmur YES NO Nervousness/Anxiety YES NO Bone Density Medication YES NO Heart Detect-Heart Murmur YES NO Nervousness/Anxiety YES NO Bone Density Medication YES NO Heart Balture YES NO Nervousness/Anxiety YES NO Bruise Easily YES NO Heart Surgery YES NO Severe Allergies/Hives YES NO Rehard Falcendary YES NO Heart Palmure YES NO Severe Allergies/Hives YES NO Chemotherapy/Radiation YES NO Heart Palmure YES NO Severe Allergies/Hives YES NO Chest Pain YES NO Heart Palmure YES NO Heart Palmure YES NO Severe Allergies/Hives YES NO Chest Pain YES NO Heaphtilis/Liver Disease YES NO Sirus Trouble YES NO Diabetes YES NO Hepathis/Liver Disease YES NO Sirus Trouble YES NO Diabetes YES NO Hilp Blood Pressure YES NO Thyroid Disease YES NO Diabetes YES NO Hilp Positive/AIDS YES NO Horty Sirus YES NO Drug/Alcohol Addiction YES NO Loss of Appetite YES NO Dental anesthetic?  Is there any other medical information not listed that we should know about?  Are you taking birth control? YES NO Loss of Appetite YES NO Dental anesthetic?  Signature of Patient/Parent/Legal Guardian Date Dr Initials Date    Date   Patient Initials   Doctor Initi			е	YES	_				_
Alzheimer's/Dementia	·			MEDICAL LUCT	ODV				
Alzheimer's/Dementia YES NO Emphysema YES NO Loss of Sleep YES NO Anemia YES NO Epilepsy or Seizures YES NO Low Brood Pressure YES NO Arthritis YES NO Fainting/Dizzy Spells YES NO Low Brood Pressure YES NO Arthritis YES NO Fainting/Dizzy Spells YES NO Low Brood Pressure YES NO Arthritis YES NO Fainting/Dizzy Spells YES NO Low Brood Pressure YES NO Arthritis YES NO Fainting/Dizzy Spells YES NO Low Brood Pressure YES NO Arthritis YES NO Fainting/Dizzy Spells YES NO Low Brood Pressure YES NO Arthritis YES NO Heart Defect/Heart Murmur YES NO Multiple Sclerosis YES NO Reversite YES NO Revousness/Anxiety YES NO Brood Pressure YES NO Heart Defect/Heart Murmur YES NO Revousness/Anxiety YES NO Brood Pressure YES NO Heart Defect/Heart Murmur YES NO Revousness/Anxiety YES NO Brood Pressure YES NO Revousness/Anxiety YES NO Brood Pressure YES NO Revousness/Anxiety YES NO Severe Allergies/Hives YES NO Scleve Cell Disease YES NO Scleve Press NO Scleve Cell Disease YES NO Scleve Press NO Depression YES NO Heart Pacemaker YES NO Scleve Press NO Scleve Press NO Depression YES NO Heart Pacemaker YES NO Heart Pacemaker YES NO Revousness/Anxiety YES NO Revousness/A	Do you currently have	or hav	e voi			ina:			
Anemia YES NO Epilepsy or Seizures YES NO Loud Snoring YES NO Arthritis YES NO Frequent Cold Sores YES NO Mittral Valve Prolapse YES NO Artificial Heart Valve YES NO Frequent Cold Sores YES NO Mittral Valve Prolapse YES NO Artificial Joints YES NO Glaucoma YES NO Mittral Valve Prolapse YES NO Artificial Joints YES NO Heart Defect/Heart Murmur YES NO Heart Defect/Heart Murmur YES NO No Nervouses/Arxiety YES NO Back Problems YES NO Heart Disease/Attack YES NO Nervouses/Arxiety YES NO Bone Density Medication YES NO Heart Failure YES NO Remaitic/Scarlet Fever YES NO Cancer/Leukemia YES NO Heart Pacemaker YES NO Scave After Problems YES NO Cancer/Leukemia YES NO Heart Pacemaker YES NO Scave After YES NO Chest Pain YES NO Hepatitis/Liver Disease YES NO Sickle Cell Disease YES NO Depression YES NO Hepatitis/Liver Disease YES NO Stroke YES NO Difficulties Breathing YES NO High Blood Pressure YES NO Thyroid Disease YES NO Difficulties Breathing YES NO Loss of Appetite YES NO Drug/Alcohol Addiction YES NO Loss of Appetite YES NO Adverse reaction to YES NO Drug/Alcohol Addiction YES NO Loss of Appetite YES NO Dental anesthetic?  Is there any other medical information not listed that we should know about?  Are you pregnant/trying to become pregnant? YES NO If yes, how long? How often?  YES NO Do you use tobacco products? YES NO If yes, how long? How often?  YES NO If yes, how long? How often?  Signature of Patient/Parent/Legal Guardian Date Dr Initials Date  (For Follow Up Visits only)  Updated Date Patient Initials Doctor Initials  Updated Date Patient Initials Doctor Initials				i			Loss of Sleen	YES	NO
Arthritis YES NO Artificial Heart Valve YES NO Artificial Heart Valve YES NO Artificial Heart Valve YES NO Frequent Cold Sores YES NO Mittral Valve Prolapse YES NO Arthritical Joints YES NO Glaucoma YES NO Multiple Sclerosis YES NO Asthma YES NO Heart Defect/Heart Murmur YES NO Multiple Sclerosis YES NO Bone Density Medication YES NO Heart Defect/Heart Murmur YES NO Bone Density Medication YES NO Heart Failure YES NO Psychiatr Treatment YES NO Cancer/Leukemia YES NO Heart Surgery YES NO Severe Allergies/Hives YES NO Chemotherapy/Radiation YES NO Heart Surgery YES NO Sicke Cell Disease YES NO Chest Pain YES NO Hemophilia/Rileeding issues YES NO Sicke Cell Disease YES NO Diabetes YES NO High Blood Pressure YES NO Diabetes YES NO High Blood Pressure YES NO Drug/Alcohol Addiction YES NO High Blood Pressure YES NO Drug/Alcohol Addiction YES NO Loss of Appetite YES NO Drug/Alcohol Addiction YES NO Loss of Appetite YES NO Dental anesthetic?  Is there any other medical information not listed that we should know about?  Are you currently taking blood thinners? YES NO Solve Prospection to YES NO Solve Prospective YES NO Solve Prospective YES NO Dental anesthetic?  Signature of Patient/Parent/Legal Guardian Date Dr Initials Date    Date   Patient Initials   Doctor Init				. ,					
Artificial Heart Valve YES NO Grequent Cold Sores YES NO Mittal Valve Prolapse YES NO Artificial Joints YES NO Glaucoma YES NO Multiple Sclerosis YES NO Asthma YES NO Heart Defect/Heart Murmur YES NO Multiple Sclerosis YES NO Back Problems YES NO Heart Defect/Heart Murmur YES NO Psychiatric Treatment YES NO Back Problems YES NO Heart Defect/Heart Murmur YES NO Psychiatric Treatment YES NO Bruse Easily YES NO Heart Failure YES NO Psychiatric Treatment YES NO Bruse Easily YES NO Heart Surgery YES NO Severe Allergies/Hives YES NO Cancer/Leukemia YES NO Heart Pacemaker YES NO Sickle Cell Disease YES NO Chemotherapy/Radiation YES NO Heapthilia/Bleeding issues YES NO Sickle Cell Disease YES NO Chest Pain YES NO Hepatitis/Liver Disease YES NO Sickle Cell Disease YES NO Diabetes YES NO Hilp/Blood Pressure YES NO Stroke YES NO Diabetes YES NO Hilp/Blood Pressure YES NO Thyroid Disease YES NO Diabetes YES NO Hilp/Blood Pressure YES NO Adverse reaction to YES NO Drug/Alcohol Addiction YES NO Loss of Appetite YES NO Adverse reaction to YES NO Drug/Alcohol Addiction YES NO Loss of Appetite YES NO Are you taking brinth control?  Are you use tobacco products? YES NO If yes, how long? How often?  Jets any medications or other substances that you are ALLERGIC to:  List all medications that you are taking:  Signature of Patient/Parent/Legal Guardian Date Dr Initials Date  Date Patient Initials Doctor Initials  Doctor Initials  Doctor Initials  Doctor Initials							<u> </u>		
Artificial Joints YES NO Glaucoma YES NO Multiple Sclerosis YES NC Asthma YES NO Heart Defect/Heart Murmur YES NO Nervousness/Anxiety YES NO Back Problems YES NO Heart Disease/Attack YES NO Psychiatric Treatment YES NO Bone Density Medication YES NO Heart Failure YES NO Psychiatric Treatment YES NO Bone Density Medication YES NO Heart Failure YES NO Psychiatric Treatment YES NO Bruse Easily YES NO Heart Surgery YES NO Severe Allergies/Hives YES NO Cancer/Leukemia YES NO Heart Pacemaker YES NO Severe Allergies/Hives YES NO Chemotherapy/Radiation YES NO Heart Pacemaker YES NO Sicus Trouble YES NO Chemotherapy/Radiation YES NO Hepatitis/Liver Disease YES NO Sinus Trouble YES NO Depression YES NO Hepatitis/Liver Disease YES NO Stroke YES NO Disbetes YES NO High Blood Pressure YES NO Thyroid Disease YES NO Disbetes YES NO Kidney Disease YES NO Thyroid Disease YES NO Disbetes YES NO Kidney Disease YES NO Adverse reaction to YES NO Discletes YES NO Kidney Disease YES NO Disbetes YES NO Kidney Disease YES NO Dental anesthetic?  Is there any other medical information not listed that we should know about?  Are you pregnant/trying to become pregnant? YES NO Are you use tobacco products? YES NO YES NO If yes, how long? How often?  Its all medications or other substances that you are ALLERGIC to:  List all medications that you are taking:									
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Bone Density Medication YES NO Heart Failure YES NO Rive Medication YES NO Bruise Easily YES NO Heart Surgery YES NO Severe Altergles/Hives YES NO Cancer/Leukemia YES NO Heart Pacemaker YES NO Severe Altergles/Hives YES NO Chemotherapy/Radiation YES NO Hemophilia/Bleeding issues YES NO Sickle Cell Disease YES NO Chemotherapy/Radiation YES NO Hemophilia/Bleeding issues YES NO Siruke YES NO Chemotherapy/Radiation YES NO Hemophilia/Bleeding issues YES NO Siruke YES NO Chemotherapy/Radiation YES NO Hemophilia/Bleeding issues YES NO Siruke YES NO Chest Pain YES NO High Blood Pressure YES NO Stroke YES NO Depression YES NO High Blood Pressure YES NO Thyroid Disease YES NO Difficulties Breathing YES NO HIV Positive/AIDS YES NO Use a C-Pap Machine YES NO Drug/Alcohol Addiction YES NO Loss of Appetite YES NO Adverse reaction to YES NO Drug/Alcohol Addiction YES NO Loss of Appetite YES NO Dental anesthetic?  Is there any other medical information not listed that we should know about?  Are you pregnant/trying to become pregnant? YES NO Are you taking birth control? YES NO Do you use tobacco products? YES NO If yes, how long? How often?  List any medications or other substances that you are ALLERGIC to:  List all medications that you are taking:  Signature of Patient/Parent/Legal Guardian Date Dr Initials Date  Date Patient Initials Doctor Initials  Updated Date Patient Initials Doctor Initials							1		
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Depression YES NO Diabetes YES NO High Blood Pressure YES NO Diabetes YES NO Diabetes YES NO HIV Positive/AIDS YES NO Difficulties Breathing YES NO Drug/Alcohol Addiction YES NO Loss of Appetite YES NO Drug/Alcohol Addiction YES NO Loss of Appetite YES NO Dental anesthetic?  Is there any other medical information not listed that we should know about?  Are you pregnant/trying to become pregnant? YES NO Are you taking birth control? YES NO Doyou use tobacco products? YES NO Doyou use tobacco products? YES NO If yes, how long? How often?  List any medications or other substances that you are ALLERGIC to:  List all medications that you are taking:  Signature of Patient/Parent/Legal Guardian Date Dr Initials Date  Patient Initials Doctor Initials  Updated Date Patient Initials Doctor Initials  Updated Date Patient Initials Doctor Initials									NO
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Are you currently taking blood thinners? YES NO Do you use tobacco products? YES NO If yes, how long? How often? List any medications or other substances that you are ALLERGIC to:  List all medications that you are taking:  Signature of Patient/Parent/Legal Guardian Date Dr Initials Date  (For Follow Up Visits only)  Updated Date Patient Initials Doctor Initials  Updated Date Patient Initials Doctor Initials			pregna						
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		Patient I	nitials	Doctor Initials					



## **DENTAL HISTORY**

Do you <b>pre-medicate</b> for dental visits?	YES	NO	Do you get food caught between teeth?	YES	NO			
Do you have dental fear/dental anxiety?	YES	NO	Are you self-conscious about your teeth?	YES	NO			
Are you satisfied with previous dentistry?	YES	NO	Does your jaw often feel tired or sore?	YES	NO			
Have you had a bad dental experience?	YES	NO	Do you experience TMJ issues?	YES	NO			
Do your gums bleed easily?	YES	NO	Are you aware of clenching or grinding?	YES	NO			
Are your teeth sensitive to hot/cold/sweets YE		NO	Have you ever had braces?	YES	NO			
What prompted you to seek dental care at this	time? _							
Approximately how long has it been since you	r last der	ntal clea	ning and exam?					
What would you lil	ke to cha	ange ab	out the appearance of your teeth?					
☐ Whiter ☐ Straighter ☐ Lo	onger	□ S	horter ☐ Shaped Differently ☐ Nothing					
authorize this office and its trained staff to take dental needs. I authorize this office and its tra	e x-rays a ined staf dicated a	and other f to perf nd that	on in this packet is accurate to the best of my known in this packet is accurate to the best of my known diagnostic aids needed to make proper diagnostic form all forms of treatment as indicated. I understhis embodies certain risk. I give my permission ent from other health care providers.	sis of materials	y at the			
Signature of Patient/Parent or Guardian		Date	Doctor Initials Date	—				
FINANCIAL AGRE	EMEN	<u>T</u>						
have been made. If you	are una ail to sh	able to ow up	ed at time of service, unless prior arrang make your appointment, please give us for your pre-appointed time, or cancel w p-show fee.	more t	han			
INSURANCE FILIN								
insurance company. We	will be	happy	sible for payment in full on your account, to file insurance claims for you and do cou are financially responsible for whatever	our bes	st to			
Initials ESTIMATE what they will insurance company does				,				
USE OF PHOTOG								
			and other records may be made during w-up care. I give my permission for suc					
Initials be used for purposes of i	be used for purposes of research, education, advertisement or publication.							

## **HOLLIS FAMILY DENTAL**

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

\* You May Refuse to Sign This Acknowledgement\* \_\_, have received a copy of this office's Notice of Privacy Practices. Please Print Name Signature Date For Office Use Only We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: Individual refused to sign Communications barriers prohibited obtaining the acknowledgement П An emergency situation prevented us from obtaining acknowledgement Other (Please Specify)

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