Hollis Family DENTAL

Patient Name: _____ Preferred Name: _____

Birth date: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

Phone: (H) _____ (W) _____ (C) _____

Email: _____ Married ☐ Single ☐ 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 Company: _____

Subscriber Name: _____ Subscriber Number or SSN: _____

Secondary Dental Insurance Company: _____

Subscriber Name: _____ Subscriber Number or SSN: _____

Emergency Contact Person: _____ Relationship: _____

Phone Number: _____

How did you hear about our office? _____

Hollis Family DENTAL

Patient Name: _____ Date of Birth _____

(Next two questions for Existing Patients Only)

Change in Address ☐YES ☐NO _____

Change in Dental Insurance ☐YES ☐NO _____

MEDICAL HISTORY

Do you currently have, or have you ever had any of the following:

Alzheimer's/Dementia	☐YES	☐NO	Emphysema	☐YES	☐NO	Loss of Sleep	☐YES	☐NO
Anemia	☐YES	☐NO	Epilepsy or Seizures	☐YES	☐NO	Loud Snoring	☐YES	☐NO
Arthritis	☐YES	☐NO	Fainting/Dizzy Spells	☐YES	☐NO	Low Blood Pressure	☐YES	☐NO
Artificial Heart Valve	☐YES	☐NO	Frequent Cold Sores	☐YES	☐NO	Mitral Valve Prolapse	☐YES	☐NO
Artificial Joints	☐YES	☐NO	Glaucoma	☐YES	☐NO	Multiple Sclerosis	☐YES	☐NO
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	Rheumatic/Scarlet Fever	☐YES	☐NO
Bruise 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	Hemophilia/Bleeding issues	☐YES	☐NO	Sinus Trouble	☐YES	☐NO
Chest Pain	☐YES	☐NO	Hepatitis/Liver Disease	☐YES	☐NO	Stroke	☐YES	☐NO
Depression	☐YES	☐NO	High Blood Pressure	☐YES	☐NO	Thyroid Disease	☐YES	☐NO
Diabetes	☐YES	☐NO	HIV Positive/AIDS	☐YES	☐NO	Use a C-Pap Machine	☐YES	☐NO
Difficulties Breathing	☐YES	☐NO	Kidney Disease	☐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

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

Hollis Family DENTAL

DENTAL HISTORY

Do you **pre-medicate** 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	☐YES ☐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 your last dental cleaning and exam? _____

What would you like to change about the appearance of your teeth?

☐ Whiter ☐ Straighter ☐ Longer ☐ Shorter ☐ Shaped Differently ☐ Nothing

I acknowledge that all the dental and medical history information in this packet is accurate to the best of my knowledge. I authorize this office and its trained staff to take x-rays and other diagnostic aids needed to make proper diagnosis of my dental needs. I authorize this office and its trained staff to perform all forms of treatment as indicated. I understand that the use of anesthetic agents will be used when indicated and that this embodies certain risk. I give my permission to release medical/dental information as needed to receive proper treatment from other health care providers.

Signature of Patient/Parent or Guardian	Date	Doctor Initials	Date
_____	_____	_____	_____

FINANCIAL AGREEMENT

Initials _____

Payment in full for all charges is required at time of service, unless prior arrangements have been made. If you are unable to make your appointment, please give us more than 24 hours notice. If you fail to show up for your pre-appointed time, or cancel within 24 hours, you may be assessed a $50 No-show fee.

INSURANCE FILING

Initials _____

You, the patient, are ultimately responsible for payment in full on your account, not the insurance company. We will be happy to file insurance claims for you and do our best to ESTIMATE what they will cover, but you are financially responsible for whatever your insurance company doesn't cover.

USE OF PHOTOGRAPHS AND IMAGES

Initials _____

I understand that photographs, x-rays, and other records may be made during the course of my examination, treatment and follow-up care. I give my permission for such items to 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*

I, _____ 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
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____