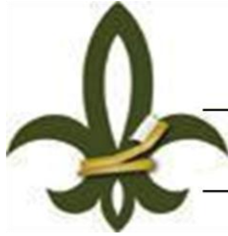

M. Megan
Hamner, DDS

Today's Date ________________

Patient Information:

Name:____________________________(Last, First, MI) Preferred Name_______________

Email:____

Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐

Date of Birth:_____/_____/_____ Age:_______ SSN:_____-_____-_____ DL#_____________

Home Address:____Apt #_____________
____(City, State, Zip)

Home Phone: (_____) _____-______ Cell Phone: (_____)_____-______
Work Phone: (_____)_____-______ ext________
Any other family member seen by us? ____

Whom may we thank for referring you?____

Person responsible for the account:
Name:____
Work #: (_____)_____-______ ext_________ Home #:_________________
Relationship:______________________ SSN:_____________________
Employer:_________________________ DL:______________________

Emergency Contact:______________________________ Phone: (_____)_____-______

Insurance:

Insurance Company:____
Insurance Co. Address:____
Insurance Co. Phone: ____
Insured/Subscriber Name:_____________________________ Date of Birth _____/_____/______
Subscriber ID/SSN:_________________________ Relationship to patient:________________
Insured's Employer:____

Employment:

Employer:___________________________________ Phone: (_____)_____-______ ext________
Employer's Address:____

Medical History:

Emergency Contact:______________________________ Phone(_____)_____-______ ext______
Do you have a personal physician? ☐Yes ☐No
Physician's Name:______________________________ Phone(_____)_____-_____ext_______

Are you currently under the care of a physician? ☐Yes ☐No

Your current physical health is: ☐ **GOOD** ☐ **FAIR** ☐ **POOR**

Do you smoke or use tobacco in any other form? Yes No

Have you had any metal rods, pins, or implants? Yes No

Date of placement __________________

Name of surgeon ___________________

Are you taking any prescriptions/over the counter or herbal supplemental drugs? Yes No

Please list each one:

____

____

Have you ever taken Fosamax, or any other bisphosphonate? Yes No

Have you ever taken Phen-Fen? Yes No

For Women: Are you pregnant? Yes No Week#__________

Are you nursing? Yes No

Please circle the condition if you have ever had any of the following diseases or medical problems:

Abnormal Bleeding	Alcohol/Drug Use	Anemia
Arthritis	Artificial Bones/Joints/Valves	Asthma
Blood Transfusion	Cancer/Chemotherapy	Colitis
Congenital Heart Defect	Diabetes	Difficulty Breathing
Emphysema	Epilepsy	Fainting Spells
Frequent Headaches	Glaucoma	Hay Fever
Heart Attack	Heart Murmur	Heart Surgery
Excessive Bleeding	Hepatitis A / B / C other	Herpes/Fever Blisters
High Blood Pressure	HIV+/AIDS	Hospitalized for Any Reason
Kidney Problems	Liver Disease	Low Blood Pressure
Lupus	Mitral Valve Prolapse	Osteoporosis/Paget's Disease
Pacemaker	Psychiatric Problems	Radiation Treatment
Rheumatic/Scarlet Fever	Seizures	Shingles
Sickle Cell Disease/Traits	Sinus Problems	Stroke
Thyroid Problems	Tuberculosis (TB)	Ulcers
Venereal Disease		

Please list any serious medical condition(s) that you have ever had if not listed above:

____

____

<u>Allergies:</u>

Are you allergic to any of the following? (please circle all that apply)

Aspirin	Erythromycin	Tetracycline
Codeine	Latex	Other
Penicillin	Novocaine (Local Anesthetic)	

Please List any other drugs/materials that you are allergic to:

____

____

Dental History:

Why have you come to the dentist today?

____

____

-Do you require antibiotics before dental treatment?	Yes	No
-Are you currently in pain?	Yes	No
-Have you ever had a serious/difficult problem associated with any previous dental work?	Yes	No
-Do you have fears/nervous about going to the dentist?	Yes	No
-Have you ever had gum treatment or been told that you have gum disease?	Yes	No
-Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?	Yes	No

Your current dental health is (please circle) **Good** **Fair** **Poor**

Do you like your smile? Yes No

If no, what don't you like about it, what would you change?

____

____

Is your bite comfortable for chewing, biting?	Yes	No
Do you have frequent headaches?	Yes	No
Do you have any old fillings or dental work that you don't like?	Yes	No

If yes, please explain: ______________________________

What would you like to change the **MOST** in the appearance of your teeth?

____

What type of toothbrush do you use? Soft Medium Hard

How long do you use a toothbrush before replacing it? ______________________

Do you use: Dental Floss or Toothpicks How often:____________

How many times a week do you floss? ______ a day do you brush? ______

Do your gums ever bleed? Yes No

Are your teeth sensitive to heat, cold, or anything else? ________________

Are your teeth mobile (loose)? Yes No

Do you have any swelling, sores or blisters in your mouth?	Yes	No
Have you ever been instructed in how to prevent tooth decay?	Yes	No
Do you feel you have unpleasant breath at times?	Yes	No

Any other remarks you would like to add:

____

____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

____

Signature Date

<u>Payment is due in full at the time of treatment</u>

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment, and payment is due at the time of service. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. If required, I also understand a check of my credit history may be made.

____

Signature   Date

I authorize Dr. Hamner or designated staff to take x-rays, study models, photographs, and other diagnostic aids deem appropriate to make a thorough diagnosis of my dental needs. I give Dr. Hamner and employees the absolute right and permission to use my photographs and x-rays for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs/x-rays. Upon diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

____

Signature   Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.