PATIENT INFORMATION

CONFIDENTIAL

(PLEASE PRINT)

Hewlett Dental EXCELLENCE
Personalized & Comfortable

DATE _____

NAME _____ BIRTHDATE _____ SS # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ EMAIL _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

EMAIL _____ CELL PHONE _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP# _____ MEMBER ID _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP# _____ MEMBER ID _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

SIGNATURE

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ _____

PATIENT, PARENT OR GUARDIAN DATE

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

YES NO

1. ARE YOU UNDER MEDICAL TREATMENT NOW? ☐ ☐
2. HAVE YOU EVER TAKEN BONE LOSS PREVENTION DRUGS SUCH AS FOSOMAX, ACTONEL, BONIVIA OR OTHER BISPHOSPHONATES? ☐ ☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? ☐ ☐
   IF YES, WHAT MEDICATION(S) ARE YOU TAKING?
   NAME: _____
   FOR WHAT CONDITION: _____
   NAME: _____
   FOR WHAT CONDITION: _____
   NAME: _____
   FOR WHAT CONDITION: _____
   NAME: _____
   FOR WHAT CONDITION: _____
4. HAVE YOU HAD ANY MAJOR SURGERY WITHIN THE LAST YEAR? ☐ ☐
5. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

	YES	NO		YES	NO
LOCAL ANESTHETICS (EG. NOVOCAINE)	☐	☐	LATEX	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐	ASPIRIN	☐	☐

   OTHER _____
6. WOMEN ONLY:
   A. ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? ☐ ☐
   B. ARE YOU NURSING? ☐ ☐
   C. ARE YOU TAKING BIRTH CONTROL PILLS? ☐ ☐

COMMENTS

_____
_____
_____
_____
_____
SIGNATURE OF DENTIST DATE

7. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	YES	NO
HIGH BLOOD PRESSURE	☐	☐
HEART DISEASE	☐	☐
CARDIAC PACEMAKER	☐	☐
CARDIAC DEFIBRILLATOR	☐	☐
HEART MURMUR	☐	☐
HEART VALVE REPLACEMENT	☐	☐
RHEUMATIC FEVER	☐	☐
ANGINA	☐	☐
RADIATION THERAPY	☐	☐
AIDS OR HIV	☐	☐
FAINTING/SEIZURES	☐	☐
EPILEPSY/CONVULSIONS	☐	☐
DIABETES	☐	☐
HEPATITIS/JAUNDICE	☐	☐
ASTHMA	☐	☐
CANCER	☐	☐
JOINT REPLACEMENT	☐	☐
OTHER	☐	☐

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐
3. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
A. CLICKING?	☐	☐
B. PAIN (JOINT, EAR, SIDE OF FACE)?	☐	☐
C. DIFFICULTY IN OPENING OR CLOSING?	☐	☐
D. DIFFICULTY IN CHEWING?	☐	☐
4. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
5. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
6. WOULD YOU LIKE YOUR TEETH WHITER?	☐	☐
7. WOULD YOU LIKE YOUR TEETH STRAIGHTER?	☐	☐

Cancellation Policy

Patients are required to inform the office at least 24 hours' notice prior to cancelling or rescheduling an appointment. Failure to do so will result in a $65 cancellation fee.

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X _____ _____

PATIENT, PARENT OR GUARDIAN DATE