HAMMOND
AESTHETIC & FAMILY DENTISTRY

WELCOME

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.
The better we communicate, the better we can care for you.

1 ABOUT YOU

Name _____

Preferred Name _____ ❑ Male ❑ Female

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Birthday ___/___/___ Age ____ SS # ___-___-____

Address _____

City _____ State _____ Zip _____

Email _____

Home # _____ Work # _____

Mobile # _____ Fax # _____

Whom may we thank for referring you? _____

Other family members seen by us _____

Last visit date _____

Employer _____ Employer Ph.# _____

Employer Address _____

How long employed there? _____

SPOUSE INFO

Name _____

Home # _____ Work # _____

Mobile # Birthdate ___/___/____

Email _____

2 ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____

Home # _____ Work # _____

Mobile # _____ Birthdate ___/___/____

Email _____

Billing Address _____

City _____ State _____ Zip _____

Thank you for filling out this form completely. It will allow us to serve you more effectively. If you have a question at any time, please ask us. We are happy to help.

3 INSURANCE

Provider Name _____

Provider Address _____

City _____ State _____ Zip _____

Phone # _____

Group # _____

ID # _____

Insured's Birthdate _____

Insured's Employer _____

Insured's Ph # _____

Insured's SS # _____

**ID# is sometimes different than SS#*

IF YOU HAVE A SECONDARY INSURANCE PLEASE LET A TEAM MEMBER KNOW.

4 REMINDER INFO

Because we know your life is busy, we use an electronic appointment reminder and messaging system. Please check all that you prefer, as our best way to contact you.

❑ Email Only ❑ Text Message Only ❑ Text Message & Email

5 REMINDER INFO

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name _____ Relation _____

Home # _____ Work # _____

6 MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name _____

Phone # _____ Last visit date _____

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

Please explain _____

Your current physical condition Good Fair Poor

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

Are you taking any prescription/over-the-counter or herbal supplement drugs? ❑ Yes ❑ No

Please list each one: _____

Have you ever taken Phen-Fen? ❑ Yes ❑ No

(Also known as Redux or Pondimin) If yes, when? _____

Are you taking any medications for Osteoporosis? ❑ Yes ❑ No

If so, what? _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Aspirin	Yes No	Erythromycin	Yes No	Penicillin	Yes No
Codeine	Yes No	Jewelry/Metals	Yes No	Tetracycline	Yes No
Dental Anesthetics	Yes No	Latex	Yes No	Other	Yes No

Please list any other drugs/metarials that you are allergic to:

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Abnormal Bleeding	Yes No	Herpes/Fever Blisters	Yes No
Alcohol / Drug Abuse	Yes No	High Blood Pressure	Yes No
Anemia	Yes No	HIV+ / AIDS	Yes No
Arthritis	Yes No	Hospitalized for any reason	Yes No
Artificial Bones, Joints, or Valves	Yes No	Kidney Problems	Yes No
Asthma	Yes No	Liver Disease	Yes No
Blood Transfusion	Yes No	Low Blood Pressure	Yes No
Cancer/Chemotherapy	Yes No	Lupus	Yes No
Colitis	Yes No	Mitral Valve Prolapse	Yes No
Congenital Heart Defect	Yes No	Pacemaker	Yes No
Diabetes	Yes No	Psychiatric Problems	Yes No
Difficulty Breathing	Yes No	Radiation Treatment	Yes No
Emphysema	Yes No	Rheumatic/ Scarlet Fever	Yes No
Epilepsy	Yes No	Seizures	Yes No
Fainting Spells	Yes No	Shingles	Yes No
Frequent Headaches	Yes No	Sickle Cell Disease	Yes No
Glaucoma	Yes No	Sinus Problems	Yes No
Hay Fever	Yes No	Stroke	Yes No
Heart Attack	Yes No	Thyroid Problems	Yes No
Heart Murmur	Yes No	Tuberculosis (TB)	Yes No
Heart Surgery	Yes No	Ulcers	Yes No
Hemophilia	Yes No	Venereal Disease	Yes No
Hepatitis	Yes No		

Please list any medical condition(s) that you have ever had:

MEDICAL HISTORY CONT.

Do you have trouble sleeping? ❑ Yes ❑ No

Do you feel tired or fatigued after sleep? ❑ Yes ❑ No

Do you feel like you get enough sleep at night? ❑ Yes ❑ No

Do you have a CPAP? ❑ Yes ❑ No

If so, do you wear it? ❑ Yes ❑ No

FOR WOMEN ONLY

Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week # _____

Are you nursing? ❑ Yes ❑ No

7 DENTAL HISTORY

Why have you come to the dentist today?

Has your doctor told you that 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 or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Your current dental health is Good Fair Poor

Do you like your smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

How many times a week do you floss? _____

How many time a day do you brush? _____

Type of toothbrush bristles? Hard Medium Soft

8 DISCLAIMER

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

In the event that payment in full for charges incurred is not made, I agree to pay all costs of collection including a 50% collection fee, attorney fees, and court costs.

Signature Date

Print

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

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