HILLSTREAM DENTAL

Patient Information

Date: _____

Patient Name:_____

Patient Social: _____

Phone: Home _____ Cell:_____

Address: _____

City: _____

State: _____ Zip Code: _____

E-Mail: _____

Sex: M □ F □ Age: _____ Birthdate: _____

□ Married □ Widowed □ Single □ Minor

□ Divorced □ Partnered for _____ years

Occupation: _____

Patient Employer/School: _____

IN CASE OF EMERGENCY, CONACT:

Name: _____ Phone: _____

Relationship to Patient: _____

Dental Insurance

Who is Responsible for this Account? _____

Relationship to Patient? _____

Insurance Company: _____

Is Patient Covered by Additional Insurance? Yes □ No □

Additional Insurance Company:_____

Assignment and Release:

I certify, that I, and-or my dependents have insurance coverage with _____ and assign directly to Dr. _____ insurance benefits, if any, otherwise payable to me for any services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my healthcare information and may disclose such information to the above-named insurance company for the purpose of obtaining payment of services and determining insurance benefits.

Signature: _____

Dental History

Reason for Today's Visit: _____

Former Dentist: _____

City: _____ State: _____

Date of Last Dental Visit: _____

Date of Last X-Rays: _____

What did you dislike at your previous office?

_____

_____

Place a mark on "yes" or "no" if you have had any of the following:

Bad Breath	□ Yes □ No	Mouth Breathing	□ Yes □ No
Bleeding Gums	□ Yes □ No	Mouth Pain	□ Yes □ No
Blisters on Lips or Mouth	□ Yes □ No	Pain around Ear	□ Yes □ No
Burning Sensation on Tongue	□ Yes □ No	Periodontal Treatment	□ Yes □ No
Chew on one Side of Mouth	□ Yes □ No	Sensitivity to Temperature	□ Yes □ No
Cigarette-Pipe-Cigar Smoking	□ Yes □ No	Sensitivity to Biting	□ Yes □ No
Clicking or Popping of Jaw	□ Yes □ No	Sores in your Mouth	□ Yes □ No
Dry Mouth	□ Yes □ No	Day sleepiness	□ Yes □ No
Fingernail Biting	□ Yes □ No	Snoring	□ Yes □ No
Food Collection between Teeth	□ Yes □ No		
Grinding Teeth	□ Yes □ No		
Gums Swollen-Tender	□ Yes □ No		
Jaw Pain-Tiredness	□ Yes □ No		
Lips or Cheek Biting	□ Yes □ No		
Loose Teeth	□ Yes □ No		
Loose Fillings	□ Yes □ No		

Floss:

□ Daily □ Weekly □ I could improve

Brush:

□ 1x Day □ 2x Day

□ Human, and sometimes I get lazy at night ☺

Health History

Physician's Name: _____ Date of Last Visit:_____

Place a mark on "yes" or "no" if you have had any of the following:

AIDS-HIV	□ Yes □ No	Epilepsy	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Anemia	□ Yes □ No	Fainting or Dizziness	□ Yes □ No	STDs	□ Yes □ No
Arthritis	□ Yes □ No	Glaucoma	□ Yes □ No	Shortness of Breath	□ Yes □ No
Artificial Heart Valves	□ Yes □ No	Headaches	□ Yes □ No	Sinus Trouble	□ Yes □ No
Artificial Joints	□ Yes □ No	Heart Murmur	□ Yes □ No	Skin Rash	□ Yes □ No
Asthma	□ Yes □ No	Heart Problems	□ Yes □ No	Sleep Apnea	□ Yes □ No
Back Problems	□ Yes □ No	Hepatitis Type _____	□ Yes □ No	Stroke	□ Yes □ No
Bacterial Endocarditis	□ Yes □ No	Herpes	□ Yes □ No	Swollen Feet Ankles	□ Yes □ No
Bleeding Abnormally,		High Blood Pressure	□ Yes □ No	Thyroid Problems	□ Yes □ No
Extractions or Surgery	□ Yes □ No	Jaundice	□ Yes □ No	Tonsillitis	□ Yes □ No
Blood Diseases	□ Yes □ No	Jaw Pain	□ Yes □ No	Tuberculosis	□ Yes □ No
Cancer	□ Yes □ No	Kidney Disease	□ Yes □ No	Tumor or Growth	
Chemotherapy	□ Yes □ No	Liver Disease	□ Yes □ No	Head, Neck, or Mouth	□ Yes □ No
Circulatory Problems	□ Yes □ No	Low Blood Pressure	□ Yes □ No	Ulcers	□ Yes □ No
Congenital Heart Disease	□ Yes □ No	Mitral Valve Prolapse	□ Yes □ No		
Cortisone Treatments	□ Yes □ No	Nervous Problems	□ Yes □ No		
Diabetes	□ Yes □ No	Pacemaker	□ Yes □ No		
Emphysema	□ Yes □ No	Radiation Treatment	□ Yes □ No		

Women:

Pregnant?	□ Yes □ No	Date Due: _____	**Please Provide if Pregnant:**
On Birth Control Pills?	□ Yes □ No	Nursing: □ Yes □ No	OB-GYN Name: _____
			OB-GYN Phone: _____

Medications

Please List Any Current Prescriptions,

Over the Counter Medications, or

Supplements:

Corresponding Diagnosis:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies

- □ Codeine
- □ Latex
- □ Penicillin
- □ Other: _____

OR

- □ No Known Drug Allergies

Patient Signature Date

Doctor Signature Date