Hamburg Dental Care
HamburgDentalCare.com

For Office Use Only Patient ID# ______________

WELCOME

Thank you for selecting our dental healthcare team! We strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient's Soc. Sec.#______________

Today's Date ______________

Patient Information: (*Confidential*) (PLEASE FILL OUT ALL INFORMATION)

Name ______________ Birthdate ______________ Home Phone ______________Cell # ______________

Mailing Address ______________City ______________ State ______________ Zip ______________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Email: ______________

Patient's Employer ______________Phone ______________

Employer Address ______________

If Minor, Mother's Name & Address ______________If Minor, Father's Name & Address ______________

Mother's Employer ______________Father's Employer ______________

If F/T College Student, Name of College ______________

Whom May We Thank for Referring You? ______________

Person to Contact in Case of Emergency ______________Phone ______________

Responsible Party:

Name of Person Responsible for this Account ______________Relationship to Patient ______________

Address ______________Home Phone ______________

Driver's License # (Required) ______________ Birthdate ______________

Employer ______________Work Phone ______________

Soc. Sec.#______________Is this person currently a Patient in our office? ☐ Yes ☐ No

Dental insurance Information:

Name of Insured (if different than patient) ______________Relationship to Patient ______________

Address ______________City ______________State ______Zip ______________

Insured's Birthdate ______________Insured's Soc. Sec. # ______________

Name of Employer ______________Work Phone ______________

Address of Employer ______________City ______________State ________ Zip ______________

Insurance Company ______________ Group #______________ Name of Union & Local # ______________

Ins. Co. Address ______________City ______________State ______Zip ______________

Ins. Co. Phone #______________

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? *☐ Yes ☐ No IF YES, PLEASE COMPLETE THE FOLLOWING*

Name of Insured ______________Relationship to Patient ______________

Insured's Birthdate ______________ Insured's Soc. Sec. # ______________

Name of Employer ______________Work Phone ______________

Address of Employer ______________City ______________State ________Zip ______________

Insurance Company ______________Group #______________Name of Union & Local # ______________

Ins. Co. Address ______________City ______________ State ________ Zip ______________

Ins. Co. Phone # ______________

How Much is your Deductible? ______________How Much Have You Used? ______________Max. Annual Benefit ______________

Patient Medical History

Physician_______________ Office Phone_______________ Date of Last Exam_______________

1. Are you under medical treatment now?__________ ☐ Yes ☐ No
2. Have you ever been hospitalized for any surgical operation or serious illness?__________ ☐ Yes ☐ No
3. Are you taking any medication(s) including non-prescription medicine(s)? ☐ Yes ☐ No
   3a. If yes, please list __________
4. Do you use tobacco?__________ ☐ Yes ☐ No
5. Do you use alcohol, cocaine or other drugs?______ ☐ Yes ☐ No
6. Are you wearing contact lenses?__________ ☐ Yes ☐ No
7. Are you currently taking any bisphosphonates or any other medication for osteoporosis? ☐ Yes ☐ No
8. Are you allergic to or have you had any reactions to the following?__________ ☐ Yes ☐ No
   - Local Anesthetics (eg. novocaine)__________ ☐ Yes ☐ No
   - Penicillin or other Antibiotics__________ ☐ Yes ☐ No
   - Sulfa Drugs__________ ☐ Yes ☐ No
   - Barbiturates__________ ☐ Yes ☐ No
   - Sedatives__________ ☐ Yes ☐ No
   - Iodine__________ ☐ Yes ☐ No
   - Aspirin__________ ☐ Yes ☐ No
   - Latex__________ ☐ Yes ☐ No
   - Other __________ ☐ Yes ☐ No
9. Women Only:
   a) Are you pregnant or think you may be pregnant? ☐ Yes ☐ No
   b) Are you nursing?__________ ☐ Yes ☐ No
   c) Are you taking birth control pills?__________ ☐ Yes ☐ No
10. Do you have or have you had any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
High Blood Pressure_____	☐ Yes	☐ No	Heart Disease__________	☐ Yes	☐ No	Chest Pains__________	☐ Yes	☐ No
Heart Attack__________	☐ Yes	☐ No	Cardiac Pacemaker_______	☐ Yes	☐ No	Easily Winded__________	☐ Yes	☐ No
Rheumatic Fever________	☐ Yes	☐ No	Heart Murmur__________	☐ Yes	☐ No	Stroke__________	☐ Yes	☐ No
Swollen Ankles__________	☐ Yes	☐ No	Angina__________	☐ Yes	☐ No	Hay Fever/Allergies______	☐ Yes	☐ No
Fainting/Seizures________	☐ Yes	☐ No	Frequently Tired________	☐ Yes	☐ No	Tuberculosis__________	☐ Yes	☐ No
Asthma__________	☐ Yes	☐ No	Anemia__________	☐ Yes	☐ No	Radiation Therapy_______	☐ Yes	☐ No
Low Blood Pressure______	☐ Yes	☐ No	Emphysema__________	☐ Yes	☐ No	Glaucoma__________	☐ Yes	☐ No
Epilepsy/Convulsions_____	☐ Yes	☐ No	Cancer __________	☐ Yes	☐ No	Recent Weight Loss______	☐ Yes	☐ No
Leukemia__________	☐ Yes	☐ No	Arthritis__________	☐ Yes	☐ No	Liver Disease__________	☐ Yes	☐ No
Diabetes __________	☐ Yes	☐ No	Joint Replacement or Implant	☐ Yes	☐ No	Heart Trouble__________	☐ Yes	☐ No
Kidney Disease_________	☐ Yes	☐ No	Hepatitis/Jaundice_______	☐ Yes	☐ No	Respiratory Problems_____	☐ Yes	☐ No
AIDS or HIV Infection____	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No	Other__________	☐ Yes	☐ No
Thyroid Problem________	☐ Yes	☐ No	Stomach Troubles/Ulcers__	☐ Yes	☐ No			

Patient Dental History

When was your last dental exam? __________ When were your last dental xrays taken? __________

1. Do your gums bleed while brushing or flossing?___ ☐ Yes ☐ No
2. Are your teeth sensitive to hot or cold liquids/foods? ☐ Yes ☐ No
3. Are your teeth sensitive to sweet or sour liquids/foods?__________ ☐ Yes ☐ No
4. Do you feel pain to any of your teeth?__________ ☐ Yes ☐ No
5. Do you have any sores or lumps in or near your mouth?__________ ☐ Yes ☐ No
6. Have you had any head, neck or jaw injuries?____ ☐ Yes ☐ No
7. Have you ever experienced any of the following problems in your jaw?
   a) Clicking?__________ ☐ Yes ☐ No
   b) Pain (joint, ear, side of face)?__________ ☐ Yes ☐ No
   c) Difficulty in opening or closing? __________ ☐ Yes ☐ No
8. Do you have frequent headaches?__________ ☐ Yes ☐ No
9. Do you clench or grind your teeth?__________ ☐ Yes ☐ No
10. Do you bite your lips or cheeks frequently?______ ☐ Yes ☐ No
11. Have you ever had any difficult extractions in the past?__________ ☐ Yes ☐ No
12. Have you had any orthodontic work?__________ ☐ Yes ☐ No
13. Have you ever had any prolonged bleeding following extractions?__________ ☐ Yes ☐ No
14. Have you ever had instruction in the correct method of brushing your teeth?__________ ☐ Yes ☐ No
15. Have you ever had instructions on the care of your gums?__________ ☐ Yes ☐ No
16. Is your water fluoridated?__________ ☐ Yes ☐ No

Authorization, Release and Consent

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. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a monthly billing charge may be added to my account, in addition to any collection charges.

Signature of patient or parent if minor X__________________________ **Date** __________

Print name here X__________________________ **Date** __________