WELCOME TO HALLEY'S FAMILY DENTAL CARE

Today's Date_____ Birth Date_____ Age_____

Name_____Preffered Name_____
First Middle Last

Address_____ Mobile Phone(____)_____
Street City/State Zip Code Home Phone(____)_____

Email address_____ SSN_____

Sex ____M____F Marital Status: (Circle) Single Married Widowed Divorced

Employed By_____Occupation _____Telephone (___)_____

Business Address_____**Referred By** _____

Emergency Contact: (other than spouse) Name_____

Relationship_____ Telephone (____)_____

Parent or Spouse Name_____Telephone (____)_____

Parent or Spouse Employer's Name_____

Who will pay for your account? Self Spouse Parents Other _____

How will you pay your account? Cash Personal Check Credit/Debit Card Care Credit

Dental Insurance Coverage Ins. Company_____ Group # _____
Y N Insured_____SSN _____DOB_____
Employer_____Relationship to Patient_____

MEDICAL HEALTH

General Health: (please circle one) Excellent Good Fair Poor

Name of Primary Physician_____ Telephone (____)_____

May we call your physician if necessary? Y N

Preferred Pharmacy_____ Telephone (____)_____

List any medication you are taking and for what purpose?_____

_____

_____

Have you been told by a doctor you need pre medication?.....Y N

Are you taking a blood thinner?.....Y N
Are you pregnant?……...…...Y N
Diabetes……..……Y N
Anemia……...Y N
High Blood Pressure……..Y N
Lung Disease…….……Y N
Osteoporosis……..Y N
Seizures or Epilepsy……..Y N
Rheumatic Fever……Y N

Artificial Joint (hip, knee, etc)……Y N
If yes, how many weeks pregnant?_____
Tuberculosis……...Y N
Hepatitis or HIV…….Y N
Low Blood Pressure……...Y N
Mitral Valve Prolapse……..…Y N
Stroke……Y N
Heart Disease…….Y N
Other_____

Known Allergies: Penicillin_____ Codeine_____ Local Anesthetics_____ Latex_____
Aspirin_____ Iodine_____ Others_____

(Please complete and sign reverse)

DENTAL HISTORY

Reason for today's visit_____
Are you in dental discomfort?_____When was your last dental visit?_____
Previous Dentist_____Telephone & City_____
Are you apprehensive about dental work?_____
Please circle yes or no if you have had problems with any of the following:

Bleeding Gums	Y	N	Periodontal Disease	Y	N
Bad Breath	Y	N	Sensitivity to Cold/Sweets	Y	N
Chronic Dry Mouth	Y	N	Bad Gag Reflex	Y	N
Loose Teeth	Y	N	Sensitivity when Biting	Y	N
Clenching or Grinding	Y	N	Sores in Mouth	Y	N
Clicking/Popping/Sore Jaw	Y	N	Head/Neck/Shoulder pain	Y	N

How often do you brush?_____ How often do you floss?_____
Are you satisfied with the appearance of your teeth? Y N
If you wanted to change your mouth in any way, what would you change?_____
Have you or your relatives had cancer of the mouth? Y N Relationship_____
Have you ever experienced an adverse reaction during, or in conjunction with, a medical or dental procedure? Y N
If yes, please explain_____
Do you wear: **Dentures** Y N **Partials** Y N If yes, for how long?_____
Have you had Orthodontic treatment? Y N If yes, when were you treated?_____
Have you had wisdom teeth removed? Y N If yes, when were they removed?_____
Do you use tobacco? Y N What kind of tobacco?_____For how long?_____
Please add anything else you feel may be important_____

HIPAA/PRIVACY

Do you consent to your photo being taken and/or shared on our website or any of our social media accounts to promote our practice? Y N (we will not include any names or identifiable information)

If yes, who's giving consent: Self Parent Guardian Parent name (if under 18):_____

In our efforts to comply with the "privacy rule" of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers. May we leave messages at your work or home regarding appointment time? If not, please explain_____

Please list any persons (including parent/spouse) whom we may speak with regarding your treatment:

Name_____ Name_____
Relationship_____ Relationship_____
Phone #_____ Phone #_____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date_____

Dentist Signature_____

Payment is due in full at time of treatment, unless prior arrangements have been approved.