Hancock Dental
Gentle Quality Care

WELCOME TO OUR OFFICE

Thank you for choosing our office for continuing your dental care.
In order to serve you properly we will need the following information. All information will be strictly confidential. *(Please print).*

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Home Phone _____ Mobile Phone _____ Email _____

Patient Employer _____ Occupation _____ Work Phone _____

How would you like to be notified for upcoming appointments? ☐ Email ☐ Phone ☐ Text _____
Mobile Carrier (Verizon, AT&T, Sprint, etc.)

To whom may we thank for referring you to our office? _____

Any Dental Insurance Coverage? ☐ Yes ☐ No If so, who is your carrier? _____

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Phone _____

Address *(if different from patient's)* _____ City _____ State _____ Zip _____

PATIENT DENTAL HISTORY

Please check (✓) if you have had any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal Treatment
- ☐ Sensitivity to cold or hot
- ☐ Sensitivity to sweets or biting
- ☐ Sores or growths in your mouth

ADDITIONS TO DENTAL HISTORY

- ☐ Frequent headaches
- ☐ Orthodontic work
- ☐ Prolonged bleeding following extractions
- ☐ Pain (joint, ear, side of face)
- ☐ Other _____

How often do you brush? _____ daily How often do you floss? _____ daily

If you could change something about your smile or teeth, what would it be? _____

_____

PERMISSION

Release of Information: *(please be sure to list any family members and/or power of attorney's as needed)*

I, _____, authorize Dental Health Services to discuss with _____
First & Last Name First & Last Name

in regards to my oral health, recommended treatment, dental insurance and account information.

Emergency Contact: _____ Phone _____ Relation: _____
First & Last Name

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

PATIENT MEDICAL HISTORY

Physician _____ Location _____ Date of Last Exam_____

	Yes	No
Are you under medical treatment now?	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
Are you taking any blood thinners or aspirin?	☐	☐
Are you taking any medication(s) including non-prescription medicine?	☐	☐

If yes, what medications are you taking? *(If you are not able to list them right away, please email/bring a list in.)*

- _____
- _____
- _____
- _____
- _____
- _____

Currently use of: ☐ Alcohol ☐ Tobacco ☐ Coffee

Are you allergic to, or have had any reactions to any of the following:	Yes	No
Local Anesthetic (e.g. Novocain)	☐	☐
Aspirin	☐	☐
Codeine	☐	☐
Hay Fever	☐	☐
Latex	☐	☐
Penicillin or other Antibiotics	☐	☐

Other Allergies: _____

_____

_____

_____

Women Only:

	Yes	No
Are you, or think you might be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

Do you have any of the following?

	Yes	No		Yes	No		Yes	No
Anemia	☐	☐	Heart Condition	☐	☐	Radiation Therapy	☐	☐
Arthritis	☐	☐	Heart Murmur	☐	☐	Respiratory Problem	☐	☐
Artificial Joints	☐	☐	Heart Pacemaker	☐	☐	Rheumatic Fever	☐	☐
Asthma	☐	☐	Hepatitis A, B, C	☐	☐	Sinus Trouble	☐	☐
Cancer	☐	☐	High/Low Blood Pressure	☐	☐	STD	☐	☐
Diabetes	☐	☐	AIDS / HIV Infections	☐	☐	Stomach Problem	☐	☐
Dizziness/Fainting	☐	☐	Jaundice	☐	☐	Stroke	☐	☐
Epilepsy/Seizures	☐	☐	Kidney Condition	☐	☐	Tumor/Ulcers	☐	☐
Glaucoma	☐	☐	Other _____					

AUTHORIZATION

_____ Initial — I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of the signature on all insurance submissions.

_____ Initial — I understand this practice's Notice of Privacy Practices written in plain language. This notice provides the usage of disclosure of my health information as protected by HIPAA.

_____ Initial — I understand this office has the right to alter this privacy in regards to my health information. If changes occur this practice will provide me with a revised notice of the privacy policy upon my request.

_____ Initial — I instruct the dentist and/or hygienist to deliver the care that, in their professional judgement, can best help me in the restoration of my health.

Signature _____ Date _____

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