Welcome, please tell us about yourself . . .

Date: _____

Name: _____

I prefer to be addressed as: _____

Home Address: _____

_____

Home Phone: ___

_____ Cell Phone: _____

_____ Work Phone:

_____ Ext: _____

May we contact you at this work phone? ❑ Y ❑ N Best Time: ____

E-mail: _____

❑ Male ❑ Female

Date of Birth: _____ Age: _____

Social Security: _____

Employer: _____ Occupation: _____

Employer Address: _____

_____

Other Family Members at AD: _____

_____

Whom may we thank for referring you? ___

Who was your former dentist? _____

_____ Address: _____

Phone Number:

HEALTH HISTORY . . .

Physician: _____

Clinic Location: _____

Clinic Phone Number: ___

Last Visit: _____

Pharmacy: _____

Pharmacy Phone Number: _____

EMERGENCY CONTACT INFO . . .

Name: _____

Relation: _____

Employer: _____

Contact Phone Number: _____

If other than yourself, please list the person responsible for the account: _____

Billing Address: _____

Home Phone: ___

Work Phone: _____

Relationship: _____

Date of Birth: _____

Employer: _____

FINANCIAL INFO . . .

Primary Ins: _____

Policy Holder: _____

Policy Holder Date of Birth: _____

Policy ID Number: _____ Group Number: _____

Secondary Ins: _____

Policy Holder: _____

Policy Holder Date of Birth: _____

Policy ID Number: _____ Group Number: _____

I authorize release of any information relating to claims filed by Joseph Hyde and Associated Dentists.

Signature: _____

I wish to assign benefits to Joseph Hyde and Associated Dentists, and understand that I am responsible for any co-payment and deductibles that my insurance does not cover.

I hereby certify that the information I have given here today is correct to the best of my knowledge and that payment is due in full at the time of treatment unless prior arrangements have been approved.

Signature: _____

NAME _____

I prefer to be addressed as _____

HEALTH HISTORY . . .

CURRENT MEDICATIONS *(Prescriptions and Over the Counter including herbal supplements)*

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

HAVE YOU EVER TAKEN

Y	N	
❑	❑	Blood Thinners ex. Coumadin, Warfarin
❑	❑	Steroids ex. Prednisone, Cortisone, etc.
❑	❑	Anxiety medication
❑	❑	Cancer medication such as Aredia, Zometa, etc.
❑	❑	Osteoporosis/Bone Density Medication such as Fosamax, Boniva, Actonel, etc.
❑	❑	Pre-medication for Dental Appointments

❑ ❑ Do you smoke tobacco? How much? _____

❑ ❑ Do you chew tobacco? How much? _____

❑ ❑ Have you ever been hospitalized in the last 5 years?

Have you ever had any of the following medical conditions?

Y	N		Y	N	
❑	❑	Abnormal Bleeding/ Hemophilia	❑	❑	HIV Positive/AIDS
❑	❑	Acid Reflux/Heart Burn	❑	❑	Hypoglycemia/ Low Blood Sugar
❑	❑	Anemia	❑	❑	Joint Replacement ex. Knee, Hip
❑	❑	Anxiety/Depression	❑	❑	Kidney Stones/ Kidney Disease
❑	❑	Arthritis	❑	❑	Memory Loss
❑	❑	Artificial Heart Valve	❑	❑	Neck/Back Pain
❑	❑	Asthma	❑	❑	Physical Challenges that require accommodation ex. Wheelchair, etc.
❑	❑	Auto-Immune, Skin Eczema, Lupus	❑	❑	Radiation Treatments
❑	❑	Cancer	❑	❑	Seizures
❑	❑	Chemotherapy Treatments	❑	❑	Shingles
❑	❑	Cold/Canker Sores	❑	❑	Shortness of Breath
❑	❑	Congenital Heart Defect	❑	❑	Sinus Problems
❑	❑	Diabetes	❑	❑	Snoring/Sleep Apnea
❑	❑	Drug/Alcohol Dependence	❑	❑	Stomach Ulcers
❑	❑	Eating Disorder	❑	❑	Stroke
❑	❑	Headaches (frequent)	❑	❑	Tuberculosis Exposure
❑	❑	Hearing Impaired/Loss	❑	❑	Other: _____
❑	❑	Heart Attack			
❑	❑	Heart Murmur			
❑	❑	Heart Surgery ex. Bypass, Pacemaker			
❑	❑	Hepatitis			
❑	❑	High/Low Blood-Pressure			

Women, are you . . . Pregnant? ❑ Y ❑ N # of Weeks_____ Taking oral contraceptives? ❑ Y ❑ N Nursing? ❑ Y ❑ N

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING . . .

❑ Anesthetic ❑ Aspirin ❑ Codeine ❑ Latex ❑ Metals ❑ Penicillin ❑ Tetracycline

❑ Other: _____

I have reviewed the information above and have answered to the best of my knowledge.
I understand that it is my responsibility to inform the doctor and staff of any changes to my health status.

Signature: _____ Date: _____ Reviewed by: _____

PERIODIC UPDATES . . .

DATE	CHANGE	SIGNATURE	REVIEWED BY

For Doctor s use

❑ Anes w/o Epinephrine ❑ Pre Med ❑ Other_____