

DOUGLAS HAMILL D.D.S
FAMILY AND COSMETIC DENTISTRY

Patient's Information

Today's Date: _____

Patient's Name _____ M ___ F ___ DOB _____ Age _____

Social Security Number _____ If Minor Parent/Guardian _____

Street Address _____ Apt # _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Marital Status _____

Patient's Employer _____ Employers Address _____

Physicians Name _____ Address _____ Phone _____

Parent/Guardian's Employer _____ Address _____

Dental Insurance Name _____ Group # _____

Name of Insured _____ Social Security Number _____

Relation to Patient _____ Reason for Visit _____

In Case of Emergency, Notify _____ Phone _____

Medical History

Have you ever had or have had the following? If yes, Please indicate "yes" and circle illness.

	<u>Yes.</u>	<u>No.</u>
1. Asthma, hay fever, sinusitis, or other allergies?	___	___
2. Allergy to Penicillin, aspirin, local or general anesthetic or other Drugs? Please Specify: _____	___	___
3. Blood Pressure or heart problem?	___	___
4. Rheumatic Fever or heart murmur or mitral valve prolapsed?	___	___
5. A pacemaker or open heart surgery or heart valve replacement?	___	___
6. Diabetes, liver, kidney, thyroid or lung problems?	___	___
7. Ulcer or stomach problems?	___	___
8. Hepatitis or Jaundice?	___	___
9. Epilepsy or nervous disorders?	___	___
10. Bleeding or clotting disorders?	___	___
11. Arthritis or hip replacement surgery?	___	___

	<u>Yes.</u>	<u>No.</u>
12. Communicable disease: tuberculosis, herpes or venereal	___	___
13. Acquired Immune Deficiency Syndrome (AIDS/HIV+/A/R/C)?	___	___
14. Any other illnesses?	___	___
15. Do any wounds heal slowly or present complications?	___	___
16. Are you presently taking medication?	___	___
Please specify type: _____		
What is the medication treatment for? _____		
17. Has there been any changes in your general health within the last year?	___	___
18. Are you presently under the care of a physician?	___	___
If so, conditioned being treated? _____		
19. When was your last physical? _____	___	___
20. Have you been hospitalized within the last 5 years?	___	___
If so, what was the reason? _____		
21. Have you been or are being treated with chemotherapy or radiation therapy?	___	___
22. Do you have any pins, rods or prosthetic Joints?	___	___
23. Are you taking birth control pills?	___	___
24. Are you pregnant or nursing?	___	___

Dental History

Correct answers to the following questions will allow your dentist to treat you on a more personal basis, providing the care appropriate for your particular needs. Circle which ever apply.

	<u>Yes.</u>	<u>No.</u>
1. Are you having any discomfort at this time?		
2. Have you ever had problems associated with previous dental treatment?	___	___
If so, explain. _____		
3. Does dental treatment make you nervous? No ___ Slightly ___ Moderately ___ Extremely ___		
4. What is the approximate date of last dental visit? _____		
5. Do you have clicking or a popping jaw?	___	___
6. Do you have difficulty opening or closing your jaw?	___	___
7. Are you happy with your smile	___	___
Is there anything in your smile that you would like to change?	___	___
Do you like the color of your teeth?	___	___

Note use of Novocain in rare cases can cause permanent numbness.

Whom may we thank for referring you? _____

My medical history is accurate and complete.

Patients Signature _____ Date _____

If minor, Parent/Guardian Signature _____ Date _____

Doctor Signature _____ Date _____

Witness Signature _____ Date _____