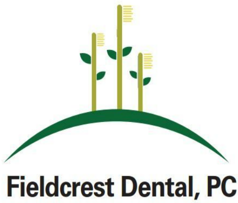

Adult Patient Health Health

How did you hear about us?

____

Name or source

Patient Name: ____

Last **First** **Middle**

Address: ____

House number & PO Box if applicable **City** **State** **Zip Code**

Home Phone: (_____) _______________________ Work Phone: (_____) _______________________

Date of Birth: ______________________________ Social Security Number: ___________________________

Male/Female (circle one) Single, Married, Separated, Divorced or Widowed (circle one)

Your Employer: ____ Position: ____________________________

Business name **City & State**

Do you have Dental Insurance through your employer? Yes or No

Name of Insurance Company: ____

Policy/Group number: ______________________________ Member ID number: ___________________________

Spouse Information

Spouse's Name: ____

Last **First** **Middle**

Date of Birth: _____________________________________ Social Security Number: ________________________

Employer: ____ Position: ____________________________

Business name **City & State**

Does your spouse have Dental Insurance through their employer? Yes or No
If yes, are you covered under their dental insurance? Yes or No

If yes, Name of Dental Insurance Company: ____

Policy/Group number: ______________________________ Member ID number: ___________________________

Who is responsible for this account: ____

Emergency contact Person: ____

Name **Relationship** **Phone#**

Revised: December 2015

List All Medications You Are Currently Taking or Should be: List All Previous Surgeries with Dates:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Have you ever taken medications for Osteoporosis? Yes / No
Do you use tobacco products? Yes / No
History of Drug/Alcohol Addiction? Yes / No
Is your General Health Good? Yes / No (if no, why) ______________________________

Currently under Doctors Care? Yes / No (if so, why) ______________________________

Physician's Name ______________________________ Phone # ________________

Women ONLY: ***Pregnant/Trying To Get Pregnant?*** *Yes / No* ***Nursing?*** *Yes / No*

Taking Oral Contraceptives? *Yes / No*

Are you allergic to any of the following?

Penicillin *Yes / No* **Codeine** *Yes / No* **Acrylic** *Yes / No* **Metal** *Yes / No* **Latex** *Yes / No*

Sulfa Drugs *Yes / No* **Other(s):**______________________________

Name **City & State**

Please list any dental/oral concerns ______________________________

Please circle any of the following conditions that you have currently or have had in the past:

Cardiovascular	***Respiratory***	***Liver/Kidney/Gastro-Intestinal***
Angina/Chest Pain	Asthma	GERD (Acid Reflux)
Congenital Heart Problems	COPD	Hepatitis
Heart Attack / Failure	Easily Winded	Kidney Problems
High / Low Blood Pressure	Emphysema	Liver Disease (Other)

Heart Surgery / Artificial Valve
High Cholesterol
Infective Endocarditis
Irregular Rhythm / Pacemaker
Murmur
Rheumatic Fever

Blood
Anemia
Hemophilia

HIV / AIDS
Bruise Easily / Thin Blood
Organ Transplant (Received or Donor)

Frequent Sinus Trouble
Other Breathing Problems
Tuberculosis

Neural / Neurovascular / Psych
Alzheimer's / Dementia
Anxiety / Depression
Epilepsy / Seizures
Fainting / Dizzy Spells
Glaucoma

Neuralgia
Psychiatric Care (Other) ______________
Stroke

Ulcers

Musculoskeletal
Arthritis / Gout
Artificial Joint
Bone / Muscle Other _____________
Osteoporosis

Cancer
Cancer (Type) __________________

Chemotherapy
Radiation Therapy

Please be sure to read, sign and date of all the bottom approvals.

Patient, Parent or Guardian:

This information has been answered to the best of my knowledge, and I will update Dr Hamper, DMD and their staff of any medical changes in the future. My signature authorizes the release of information to my insurance company and it authorizes assignment of benefits when applicable.

Signature: ________________________________ ***Date:*** ____________________________

Patient, Parent or Guardian:

I hereby agree to the following terms and conditions:

There is a 1.5% monthly late charge assessed on all balances after 90 days past due. Checks, which are declared non-sufficient funds, will be charged a $30.00 service fee. Also, the undersigned agrees to pay collections fee of 33% of the total owed when sent to collections. All attorney fees and court costs incurred by the creditor. All the information provided is correct.

I have read and understand the above paragraph in its entirety.

Signature: ________________________________ ***Date:*** ____________________________

Patient, Parent or Guardian:

NOTICE OF PRIVACY PRACTICE

I have received a Notice of Privacy Practice

Patient name (print) ___________________________________

Signature: ______________________________ Date: __________________________

Patient unable or refused to sign acknowledgement