

Kenneth F. Hinds, D.D.S., Inc.

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PATIENT INFORMATION:

Patient: _____, Age: _____, Birth date: _____

Spouse / Parent: _____,

Patient's Drivers License No: _____, Social Security Number: _____

Residence Address: _____, City / State: _____

Zip Code: _____ Phone: () _____, Cell: () _____, Email: _____

Employer: _____, Occupation: _____

Employer Address: _____, Business Phone: () _____

City / State: _____, Zip Code: _____

Spouse Employer: _____, Spouse Social Security No: _____

Employer Address: _____, Business Phone: () _____

City / State: _____, Zip Code: _____ Birth date: _____

Person to contact in case of an emergency: _____, Phone: () _____

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION:

Primary Dental Insurance: _____, Phone: () _____

Address: _____

Group No: _____, Insured B-Day: _____, Insured ID No: _____

Secondary Dental Insurance: _____, Phone: _____

Address: _____

Group No: _____, Insured B-Day: _____, Insured ID No: _____

Please Note: As you know, an insurance policy is an agreement between you and your insurance company, and we ask that all our patients be responsible for their charges, regardless of insurance involvement. However, we enjoy billing your insurance for you and helping you receive the full allowances of your policy.

FINANCIAL INFORMATION:

Select Preferred Payment Option for services rendered:

() Cash / Check, () Credit Card, () Care Credit (Dental Credit Card), Other _____

HEALTH HISTORY:

Physician's Name: _____, Phone: () _____

Address: _____

Are you presently taking any medication or pills? () Yes, () No

If Yes, Please List: _____

Have you been hospitalized in the past 5 years? () Yes, () No, Reason: _____

Are you allergic or have you reacted adversely to any of the following medications? () Yes, () No

() Penicillin, () Tetracycline, () Local Anesthetic, () Xylocaine, () Aspirin, () Codeine

() Other, List Other: _____

Premedication Required: () Yes, () No, Antibiotic _____

Women: Are you pregnant? () Yes, () No, How many months? _____ Are you nursing? () Yes, () No

Do you smoke or use chewing tobacco? () Yes, () No, How much? _____

Please indicate which or the following you have had or have at the present. Circle yes or no to each item.

Heart Attack, Date: _____	Yes No	Ulcers:	Yes No	Hepatitis A, B, or C	Yes No
Chest Pain	Yes No	Diabetes	Yes No	Venereal Disease	Yes No
Congenital Heart Disease	Yes No	Thyroid Problems	Yes No	A.I.D.S.	Yes No
Heart Murmur	Yes No	Glaucoma	Yes No	H.I.V. Positive	Yes No
High Blood Pressure	Yes No	Fen -Phen	Yes No	Cold Sore/Fever Blister	Yes No
Mitral Valve Prolapse	Yes No	Emphysema	Yes No	Blood Transfusion	Yes No
Artificial Heart Valve	Yes No	Chronic Cough	Yes No	Hemophilia	Yes No
Heart Pacemaker	Yes No	Tuberculosis	Yes No	Sickle Cell Anemia	Yes No
Rheumatic Fever	Yes No	Asthma	Yes No	Bruise Easy	Yes No
Arthritis/Rheumatism	Yes No	Hay Fever	Yes No	Liver Disease	Yes No
Cortisone Medicine	Yes No	Latex Sensitivity	Yes No	Yellow Jaundice	Yes No
Swollen Ankles	Yes No	Allergies or Hives	Yes No	Neurological Disorders	Yes No
Stroke, Date: _____	Yes No	Sinus Trouble	Yes No	Epilepsy or Seizures	Yes No
Diet(Special restrictions)	Yes No	Radiation Therapy	Yes No	Fainting or Dizzy Spells	Yes No
Artificial Joints, Yr _____	Yes No	Chemotherapy	Yes No	Nervous/Anxious	Yes No
Kidney Trouble	Yes No	Tumors	Yes No	Psychiatric Care	Yes No

Do you have any disease, condition or problem not listed that you think I should know about? () Yes, () No
 If Yes, Please Explain: _____

DENTAL HISTORY:

Reason for today's visit: _____

Previous Dentist: _____, Phone: () _____

Date last dental visit: _____, Date last full x-ray series: _____, Date last Cleaning: _____

Orthodontic Care(Braces): Yes No Year _____, Periodontal Surgery (Gums): Yes No Year _____

Have you noticed any:

Hot or cold sensitivity?	Yes No
Sensitivity to Sweets?	Yes No
Biting or Chewing discomfort?	Yes No
Mouth odor or bad taste?	Yes No
Gums bleed when brush teeth?	Yes No
Loosening of your teeth?	Yes No
Food caught between your teeth?	Yes No
Teeth discolored?	Yes No

Have you experienced:

Clicking or popping of jaw?	Yes No
Jaw pain in joint, ear or face?	Yes No
Difficulty opening, or chewing?	Yes No
Noticed change in bite?	Yes No
Grind / Clench your teeth at night?	Yes No
Sore jaw muscles in the morning?	Yes No
Headaches or neck aches?	Yes No
Worn bite plate or bite adjusted?	Yes No

Are you satisfied with:

Appearance of your teeth?	Yes No
Color of your teeth?	Yes No
Shape of your teeth?	Yes No
Overall Smile?	Yes No

Have you experienced an upsetting visit in a dental office? () Yes, () No

Does dental treatment make you nervous? () No, () Slightly, () Moderate, () Extremely

CONSENT FOR TREATMENT:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication. Dr. Hinds office follows the strict guidelines of HIPPA privacy regulations in the handling of all patient information.

A service charge of 1.5% per month (18% annum) on the unpaid balance will be charged on all accounts exceeding 90 days. We thank you for giving us at least 24 hours notice if you must change your reserved treatment time. Authorization must be signed by the patient, or guardian, or nearest relative in the case of a minor or when the patient is physically or mentally incompetent. I understand that I am fully responsible for all charges regardless of insurance coverage.

Signed: _____, Date: _____

Relationship: _____

Review by Doctor: _____, Date: _____