HAMPTON DENTAL GROUP PC

325 Meeting House Lane · Building 2 · Suite 401
Southampton · New York 11968-7000

OFFICE POLICY
EMERGENCY AND/OR FIRST VISITS ARE TO BE PAID AT THE TIME OF TREATMENT

PATIENT MEDICAL-DENTAL HISTORY

(Dr.) / (Mr.) / (Mrs.) / (Miss) / (Ms.) Date: _____

Name_____ Birthdate:_____/_____/_____

Address (Mailing):_____ City, and Zip:_____

Address (Residence):_____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Next of Kin _____ Phone: _____

Physician _____ Previous Dentist: _____

Approximate date of last physical exam _____ Last dental exam/cleaning/x-rays: _____

OCCUPATION:_____

How did you find out about us? If someone gave you our name, please give us their name so that we can thank them_____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS SO THAT WE MAY PROVIDE BETTER DENTAL CARE FOR YOU

1. Are you currently under medical treatment now? If yes, why? _____ **Y N**
2. Have you ever had any major operations? If yes, what? _____ **Y N**
3. Have you ever been hospitalized? If yes, why? _____ **Y N**
4. Do you have or have you ever had: (circle) If you need help answering these questions, tell us. **Y N**

Heart Failure
Heart Disease or Attack
High Blood Pressure
Heart Murmur
Congenital Heart Lesions
Artificial Heart Valve
Heart Pacemaker
Heart Surgery
Artificial Joint
Anemia
Kidney Trouble
Pain in Jaw Joints

Tuberculosis (TB)
Asthma
Sinus Trouble
Allergies or Hives
Diabetes
Thyroid Disease
Head & Neck Radiation
Chemotherapy
(Cancer, Leukemia)
Arthritis
Cortisone Medicine
AIDS
Hepatitis A (infectious)

Hepatitis B (serum)
Liver Disease
Yellow Jaundice
Drug Addiction
Hemophilia
Venereal Disease
(Syphilis, Gonorrhea)
Cold Sores
Epilepsy or Seizures
Fainting or Dizzy Spells
Psychiatric Treatment
Nervousness

5. Have you ever received intravenous (IV) bisphosphonates such as Zometa (Zoledronate) or Pamidronate (Aredia)?_____**Y N**
If treated, please list the dates that bisphosphonates therapy was started and stopped:_____
_____

6. Have you ever taken oral bisphosphonates such as Fosamax, Actonal orBoniva?_____**Y N**
If treated, please list the dates that oral bisphosphonates therapy was started and stopped:_____
_____

10. Women – Could you be pregnant at this time? Y N
11. Have you ever had a reaction to these? Aspirin, Codeine, Penicillin, Novocaine or other dental anesthetics Y N
12. Have you had problems with dental treatment in the past? If yes, what? _____ Y N
13. Are you here for: Check Up (exam) Y N
    Toothache Y N
    Other _____ Y N
14. How often do you floss? _____
15. Do your gums bleed while brushing? Y N
16. Do your gums bleed while flossing? Y N
17. Do you clench or grind your jaws while sleeping or during the day? Y N
18. Do your jaws ever feel tired? Y N
19. Do you usually have many cavities? Y N
20. Do you gag easily? Y N
21. Are you completely happy with the appearance of your teeth? Y N
22. Have you ever had oral surgery or periodontal surgery? Y N
23. Have you had any history of orthodontics, including an occlusal guard, night guard or retainer? Y N
24. List any prescription medications that you are taking: _____

_____

CONSENT FOR DENTAL TREATMENT

Patient's Full Name: _____

Permission is hereby granted to examine the above-named patient, administer anesthetics and to employ such operative or technical procedures as may be deemed necessary or advisable in the diagnosis or treatment of the dental condition of the above-named patient.

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if any medicines change, I will inform the dentist at the next appointment without fail.

_____ _____

Date Signature of Patient, Parent, or Guardian

SOCIAL SECURITY NO.	TYPE OF DENTAL INSURANCE (if applicable)

WHO IS FINANCIALLY RESPONSIBLE FOR DENTAL BILL?

NAME _____ PLACE OF EMPLOYMENT _____

ADDRESS _____ ADDRESS _____

_____ _____

TELEPHONE _____ TELEPHONE _____

FINANCIAL DATA: (Must check one)

_____ Cash or check at each appointment

_____ Master Card,Visa or Discover at each appointment

_____ Credit arrangement with Financial Secretary

I understand that Hampton Dental Group, P.C. is not a participating provider with any dental plan/insurance company/benefit fund, etc. and that I am financially responsible for my dental bill.*

*As a courtesy to our patients, Hampton Dental Group, P.C. will attempt to maximize your dental plan's coverage as long as your plan allows the option for out-of-network providers.

_____ _____

Date Signature of Patient, Parent, or Guardian