G. BROOKS HANEY DDS – NEW PATIENT FORMS

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Date _____

Last Name _____First Name _____M. I. _____ Prefer to be called by _____

Birth date _____ Age _____ Male _____ Female _____

If minor, parent/guardian names _____ Home phone _____ Work phone _____

Cell Phone _____ Fax _____ Email address _____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____

❑ Married ❑ Single ❑ Divorced ❑ Widowed

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

Person to contact for Emergency _____ Phone numbers _____ _____

Emergency Contact Address _____ City _____ St _____ Zip _____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____ Group # _____

Employer Name _____ Insured's Name _____ Date of Birth _____

Relationship to patient _____ Insured's ID Number _____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Social Security number _____

_____

For Minors: School _____ Grade _____ SS# _____

Person Financially Responsible For Account _____Relationship to Patient _____

Address _____ City _____State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

HEALTH HISTORY

IN ORDER TO PROVIDE THE BEST CARE POSSIBLE FOR YOUR PARTICULAR NEEDS, PLEASE FILL THIS FORM OUT CAREFULLY.

NAME:_____**BIRTHDATE:**_____**AGE:**_____

WHAT IS YOUR MAIN REASON FOR SEEKING DENTAL TREATMENT?

_____

1. Physicians Name _____ Phone _____
   Have you had any medical care within the last 3 years? Yes _____ No _____
   If yes, describe _____
2. Have you taken any medications or drugs during the past 2 years? Yes _____ No _____
3. Are you currently taking any medications, drugs, herbal remedies, or pills (such as regular dosages of aspirin)? Yes ____ No ____
   If yes, please list drug names, dosages, and frequency _____
   _____
4. Have you ever taken prescription medications for weight loss (diet pills)? Yes _____ No _____
   If yes, did you take any of the following (check if yes): ❑ Fen-Phen ❑ Pondimen ❑ Redux ❑ Other
   If yes to any of the above, did you have a medical exam for heart tissues? Yes _____ No _____
5. Have you ever taken bone loss prevention medication such as Fosomax, Boniva, Actonel, or others? Yes _____ No _____
6. Have you been hospitalized during the past 5 years? Yes _____ No _____
7. Do you use tobacco in any form? If yes, how much? Yes _____ No _____
8. Are you allergic to any medication? Yes No
   If so, please list: _____

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Heart ailment or Angina – Heart Surgery or Attack
- ❑ Chest Pain
- ❑ Heart murmur, Mitral Valve Prolapse, Heart Defect
- ❑ Rheumatic fever or Rheumatic heart disease
- ❑ Artificial Heart Valve
- ❑ Congenital Heart Disease
- ❑ High or Low blood pressure
- ❑ Pacemaker
- ❑ Cortisone Medication
- ❑ Swollen Ankles
- ❑ Arthritis/Rheumatism
- ❑ Stroke
- ❑ Diet (Restricted or Special)
- ❑ Artificial Joints (knee, hip, etc.)
- ❑ Kidney Disease
- ❑ Ulcers
- ❑ Diabetes
- ❑ Thyroid Problems
- ❑ Glaucoma
- ❑ Contact Lenses
- ❑ Chronic cough
- ❑ Emphysema
- ❑ Asthma
- ❑ Tuberculosis or other Lung problems
- ❑ Hay Fever/Allergy/Hives
- ❑ Latex Sensitivity
- ❑ Sinus Trouble
- ❑ Radiation Therapy
- ❑ Chemotherapy
- ❑ Tumors or Cancer
- ❑ Hepatitis A B C (circle)
- ❑ Liver Disease/Yellow Jaundice
- ❑ Venereal Disease
- ❑ Alcoholism
- ❑ Blood Transfusion
- ❑ Hemophilia
- ❑ Sickle Cell Disease
- ❑ Bruise Easily
- ❑ Anemia or Blood disorders
- ❑ Abnormal Bleeding after extractions, surgery, or trauma
- ❑ Emotional condition
- ❑ Herpes or cold sores, fever blisters
- ❑ AIDS or HIV positive
- ❑ Migraine Headaches or frequent Headaches
- ❑ Neurologic Disorders
- ❑ Epilepsy, Seizures, or Fainting spells
- ❑ Nervous/Anxious
- ❑ Psychiatric/Psychological Care

9. Do you smoke or use chewing tobacco? ❑ yes ❑ no
10. Are you aware of having an allergic (or adverse) reaction to any substance or medication? Yes_____ No _____
11. Have you lost or gained more than 10 pounds in the past year? Yes _____ No _____
12. WOMEN: Are you pregnant or do you think that you could be pregnant? Yes _____ Months No _____
    Nursing? Yes _____ No _____
13. Do you use birth control prescriptions? Yes _____ No____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ Blood pressure medication
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Thyroid medication
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Recreational drugs
- ❑ Heart medications
- ❑ Other:_____

_____

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocaine")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

List any other important medical information here:

_____
_____
_____
_____
_____
_____

If "YES" to any of the above, please list the name of the medication and dosage below

1. _____
2. _____
3. _____
4. _____

Do you have any disease, condition, or problem not listed above?_____

_____

Please add anything else you would like us to know about:_____

_____

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 doctor of any changes in my health or medication to help keep my records updated.

Patient/Guardian Signature_____ Date_____

HISTORY REVIEW:

Dentist Signature: _____ Date _____

DENTAL HISTORY

Patient Name:
Date:
Medical Alert: (Allergy, Premed)

Welcome to the office of Dr. Brooks Haney. In order to provide you with the best possible dental care please carefully complete the following Dental History Form to best of your ability. Thank you.

What is the main reason you are seeking dental treatment now? _____
_____
What was done at your last dental visit? _____
_____
Date of Last Dental Visit _____Last X-rays _____ Last Dental Cleaning _____
Name of Previous Dentist _____
Address (include state/zip) _____
Telephone of previous dentist _____

Have you ever had any serious trouble associated with previous dental treatment? Yes No
If so, explain _____
Are you nervous about having dental treatment? Yes No
If "Yes, what is your biggest concern? _____
How often do you have dental examinations?
How often do you brush? _____ How often do you floss? _____
Do you use any special dental aids? (Sonic brush, Water Pik, etc.) Yes No list: _____
Have you ever used or are you currently using Topical Fluoride? Yes No

Do you have any dental problems at this time? Yes No
If "Yes", please describe: _____

Questions about your TEETH:

Hot or cold sensitivity?	Yes	No
Sensitivity to sweets?	Yes	No
Biting or Chewing sensitivity?	Yes	No
Loose teeth?	Yes	No
Food impaction between teeth?	Yes	No
Clenching and/or grinding?	Yes	No
Change in your bite?	Yes	No

Questions about your HABITS:

Clench or grind while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have OSA – Sleep Apnea?	Yes	No
Hold foreign objects between teeth?	Yes	No
Smoke/chew – use tobacco products?	Yes	No
Mouth breather – awake or asleep?	Yes	No

Questions about ORAL HYGIENE:

Do you brush regularly?	Yes	No
How often do you brush? _____		
Do you floss regularly?	Yes	No
Do you rinse with Fluoride?	Yes	No
Any other rinses?	Yes	No
Other _____		

Questions about your DENTAL HISTORY:

Have you had orthodontics (braces)?	Yes	No
Do you wear retainers?	Yes	No
Oral Surgery?	Yes	No
History of Periodontal Treatment (Gum)?	Yes	No
Has your bite been ground or adjusted?	Yes	No
Any serious injury to head or mouth?	Yes	No

If so, describe _____
_____

Questions about your MOUTH & JAW:

Bleeding or sore gums?	Yes	No
Bad breath, odors, or unpleasant taste?	Yes	No
Parents or siblings had gum disease?	Yes	No
Frequent cold sores, blisters, lesions?	Yes	No
Swelling or lumps in the mouth?	Yes	No
Clicking or popping of the jaw?	Yes	No
Pain in joint, ear, or side of face?	Yes	No
Difficulty opening or closing?	Yes	No
Difficulty chewing on either side?	Yes	No
Headaches, neck or shoulder aches?	Yes	No
Sore muscles in neck, jaw, shoulders?	Yes	No

Satisfied with Appearance of your teeth? Yes No
If "No", what would you like to change?
_____
Is there anything else you would like us to know: _____
_____
_____

CONSENT FOR TREATMENT

1. I hereby authorize doctor and designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (patient name) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper dental care.

3. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents entails certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent for the doctor's staff or designees to use and disclose any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, or operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is readily available.

5. Lastly, I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made in advance. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

_____

Patient Date

_____

Parent or Guardian Relationship