Welcome to Hewlett Family Dental

Patient Information

Date____/____/_____Patient Name_____Date of Birth____/____/_____SSN_____

Gender: M / F Primary Phone_____Secondary Phone_____

Address_____City_____State_____Zip_____

Select One: Married / Single / Divorced / Separated / Partnered / Minor

Employer or School_____Employer/School Phone_____

Emergency Contact_____Emergency Contact Phone_____

Whom may we thank for referring you?_____

Person responsible for account_____Relationship to patient_____

Responsible Party Information (Complete if responsible party is NOT the patient):

Date of Birth____/___/_____Social Security Number_____Phone_____

Address_____City_____State_____Zip_____

Employer_____Occupation_____Employer Phone_____

Primary Insurance

Insurance Company_____Subscriber Name_____Subscriber Date of Birth_____/_____/_____

Member ID Number_____SSN:_____Insurance Phone_____

Claims Address_____City_____State_____Zip_____

Secondary Insurance

Insurance Company_____Subscriber Name_____Subscriber Date of Birth_____/_____/_____

Member ID Number_____SSN:_____Insurance Phone_____

Claims Address_____City_____State_____Zip_____

Financial and Insurance Agreement

As a courtesy, we will submit your dental insurance claim to your dental insurance company. Your estimated payment for services is due at the time of service. Once final benefit payment is received, we will send you a billing statement for any balance due.

By signing below, I agree to be financially responsible for all charges for all services and materials not paid by my dental plan or covered by my plan if applicable. To the extent permitted by law, I consent to the dental office's use and disclosure of my protected health information to carry out payment activities in connection with the insurance claim. I hereby authorize and direct payment of the dental benefits directly to Dr. Mark Hewlett.

If patient does not have insurance coverage: I agree to be financially responsible for and pay in full for all services rendered at the time of service, unless a payment agreement has been reached prior to the service date.

_____

Signature of Patient or Legal Guardian or Representative **Date**

_____

Printed Name of Patient or Legal Guardian or Representative **Date**

_____

Doctor or Witness Signature **Date**

Medical History

Are you under medical treatment now? Yes/No Reason_____

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? Yes/No

Reason_____

Do you use controlled substances? Yes/No If yes, list substance(s)_____

List all medications you are currently taking:	List all allergies:

Have you ever had:

Artificial Joints Yes/No Date of surgery_____**Surgeon's name**_____

Implants Yes/No Date of surgery_____**Surgeon's name**_____

Blood Disease Yes/No Type_____

Cancer Yes/No Type_____**Treatment**_____

Do you use tobacco? Yes/No Type_____

For women only:

	Yes	No
Are you pregnant or think you may be pregnant?	□	□
Are you nursing?	□	□
Are you taking oral contraceptives?	□	□

Indicate if you have or have had any of the following:

	Yes	No		Yes	No		Yes	No		Yes	No
Anemia	□	□	Cough up Blood	□	□	HIV/AIDS	□	□	Shortness of Breath	□	□
Angina	□	□	Diabetes	□	□	Jaw Pain	□	□	Seizures	□	□
Arthritis	□	□	Emphysema	□	□	Kidney Disease	□	□	STD	□	□
Artificial Heart Valves	□	□	Epilepsy	□	□	Liver Disease	□	□	Skin Rash	□	□
Asthma	□	□	Fainting	□	□	Low Blood Pressure	□	□	Stomach Problems	□	□
Back Problems	□	□	Fatigue	□	□	Mitral Valve Prolapse	□	□	Stroke	□	□
Chemical Dependency	□	□	Glaucoma	□	□	Pacemaker	□	□	Swelling of Feet/Ankles	□	□
Chemotherapy	□	□	Heart Murmur	□	□	Radiation Treatment	□	□	Thyroid Problems	□	□
Chest Pains	□	□	Heart Disease	□	□	Recent Weight Loss	□	□	Tonsillitis	□	□
Circulatory Problems	□	□	Heart Attack	□	□	Respiratory Disease	□	□	Tuberculosis	□	□
Contact Lenses	□	□	Hemophilia	□	□	Rheumatism	□	□	Ulcer	□	□
Cortisone Treatments	□	□	Hepatitis/Jaundice	□	□	Rheumatic Fever	□	□	Other (List Below)	□	□
Cough, Persistent	□	□	High Blood Pressure	□	□	Scarlet Fever	□	□			

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Dental History

Reason for today's visit_____**Date of last dental care**_____

Date of last dental x-rays_____**Name of former dentist**_____

Do you wear dentures? Yes/No Date of placement_____

Have you had orthodontic treatment? Yes/No

Is there anything about your smile you would like to change?_____

Indicate if you've had problems with any of the following:

	Yes	No		Yes	No		Yes	No
Bad breath	□	□	Food collection between teeth	□	□	Pain – jaw/ear/face	□	□
Biting lips or cheeks	□	□	Grinding or Clenching teeth	□	□	Periodontal treatment	□	□
Bleeding gums	□	□	Head, neck, or jaw injury*	□	□	Sensitivity to cold	□	□
Clicking or popping jaw	□	□	**date of injury*_____			Sensitivity to hot	□	□
Difficulty chewing	□	□	**type of injury*_____			Sensitivity to sweets	□	□
Difficulty opening jaw	□	□	Headaches	□	□	Sensitivity when biting	□	□
Difficulty closing jaw	□	□	Loose teeth or broken fillings	□	□	Sores or growths in your mouth	□	□

Release and Authorization

By signing below I hereby authorize Dr. Hewlett and his associates to provide dental services, prescribe, dispense and/or administer any drug, medicament, antibiotic, or local anesthetic(s) that he or his associates deem, in their professional judgment, necessary or appropriate in my care or the care of my child. I certify that I have read and understand the above information to the best of my knowledge, and that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my/my child's health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

_____

Signature of Patient or Legal Guardian or Representative Date

_____

Printed name of patient or Legal Guardian or Representative **Date**

_____

Doctor or Witness Signature **Date**