Hallmark Family Dental

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form completely. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date: _____ Home Phone (____) _____ Cell Phone (____)
Name: _____ SS#: _____
Address: _____ E-mail: _____
City: _____ State: _____ Zip:
Sex: ___M ____F Age: _____ Birthdate: _
___Married ___Widowed ___Single ___Minor ___Separated ___Divorced
Whom may we thank for referring you?_____
In case of emergency, who should be notified?

Person Responsible for Account:
Relation to Patient: _____ Birthdate: _____ SS#: _____
Address (if different from patient's): _____
Phone: (__)_____ City:_____ State: _____ Zip: __
Person Responsible Employed by: _____ Occupation:
Business Address: _____ Business Phone: (__)
Insurance Company: _____ Dental/Member Services Number:
Subscriber #: _____ Group #: _____
Names of other dependents under this plan: _____

Primary Insurance

Dental History

Reason for Today's Visit: _____ Date of Last Dental Care: _____
Former Dentist: _____ Date of Last Dental X-rays: ___ ___
Address: _____ Check ( ) if you have had any of the following: ___Bad breath ____Grinding ___Sensitivity to heat ___Bleeding Gum ___Loose teeth or broken fillings ___Sensitivity to sweets ___Clicking or Popping ___Periodontal treatment ___Sensitivity when biting ___Food collection between teeth ___Sensitivity to cold ___Sores or growth in your mouth

How often do you floss? _____ How often do you brush?

Medical History

Physician's name: _____Date of last visit:

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ____ Yes ____No

Have you had any serious illnesses or operations? ____ Yes ____No
If yes, describe:_____
Have you ever had a blood transfusion? ____ Yes ____No
If yes, give approximate date: _____ _
(WOMEN) Are you pregnant? ____Yes ____No Nursing? ____ Yes ____ No
Taking birth control pills? ____Yes ____No

Please circle if you have or have had any of the following:

Anemia	**Cortisone Treatment**	**Hepatitis**	**Scarlet Fever**
Arthritis, Rheumatism	**Cough, Persistent**	**High Blood Pressure**	**Shortness of breath**
Artificial Heart Valves	**Cough up blood**	**HIV/AIDS**	**Skin Rash**
Artificial Joints	**Diabetes**	**Jaw Pain**	**Stroke**
Asthma	**Epilepsy**	**Kidney disease**	**Swelling of feet/ankles**
Back problems	**Fainting**	**Liver disease**	**Thyroid problems**
Blood disease	**Glaucoma**	**Mitral Valve prolapse**	**Tobacco habit**
Cancer	**Headaches**	**Pacemaker**	**Tonsillitis**
Chemical Dependency	**Heart Murmur**	**Radiation Treatment**	**Tuberculosis**
Chemotherapy	**Heart Problems**	**Respiratory disease**	**Ulcer**
Circulatory Problems	**Hemophilia**	**Rheumatic fever**	**Venereal disease**

Other:

What medications are you taking? __
What medications are you allergic to?

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign direction to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-names dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

I certify that the information above is correct and complete.

_____ _____
Signature of patient, guardian or personal representative **Date**

_____ _____
Please print name of patient, parent, guardian or personal representative. **Relationship to patient**