William J. Hall D.D.S. P.A.

1090 Patrick Street, Suite B
Frederick, MD 21703-3967
301-662-6247

GENERAL INFORMATION

NAME _____
How should we address you? _____
How were you referred to our office? _____
Whom may we thank for referring you?_____

Patient

Birthdate _____ Age ____ SS# _____ Martial Status _____ Male/ Female_____
Address _____
Home Phone _____ Work Phone _____
E-Mail _____ Cell Phone _____
Employer_____ Occupation _____
Employers address _____
Spouse's Name_____ Birthdate _____
Home Phone _____ Work Phone_____ Cell Phone_____
Employer _____ Occupation _____

Emergency Notification Information
Name _____ Home Phone _____ Other Phone _____
Name _____ Home Phone _____ Other Phone _____

Dental Insurance Information

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, regardless of insurance coverage, and is due and payable at the time of services are rendered unless financial arrangements have been made.

Primary Policy

Policy Holder's Name _____ ID# _____
Dental Insurance Company _____ Group# _____
Claims address _____
Policy Holder's Employer _____

Secondary Policy

Policy Holder's Name_____ ID# _____
Dental Insurance Company_____ Group# _____
Claims Address_____
Policy Holder's Employer _____

Patients Rights & Consent

The dental and medical profiles I have provided are complete and accurate. I request the dentist, the practice and qualified staff to perform assessment and diagnostic procedures for the purpose of determining my oral health condition and treatment options (including x-rays and photographs.) As a patient, I understand that I have the right to:

- Be advised of the benefits, options and risks of any dental procedure
- Ask questions and receive complete answers regarding my oral health
- Make an informed decision to accept or decline recommended treatment

I authorize the practice to consult with or transfer my dental records to/from a medical doctor, specialist or another dentist if necessary or requested. I authorize the practice to exchange information with my insurance providers (if any) for the purpose of administering my claims.

_____ _____
Signature Date

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MEDICAL HISTORY

Name _____

Your Primary Physician's Name _____ Last Visit _____

Are you being treated by a physician now? ☐ Yes ☐ No If yes why? _____

Any recent serious illness? ☐ Yes ☐ No Explain _____

Are you presently taking any medications? ☐ Yes ☐ No ☐ See attached

(including non-prescription drugs) If yes, please list _____

_____

_____

_____

Any medical reasons that require you to take an antibiotic prior to any dental treatment

☐ Yes ☐ No. If yes what antibiotic are your require to take: _____

Do you have or have you had any of the following?

Yes	*No*		*Yes*	*No*		*Yes*	*No*	
☐	☐	Acid Reflux	☐	☐	AIDS (HIV)	☐	☐	Anemia
☐	☐	Artificial Heart Value	☐	☐	Artificial Joint	☐	☐	Arthritis/ Rheumatism
☐	☐	Asthma	☐	☐	Blood Disorder	☐	☐	Blood Thinner
☐	☐	Blood Transfusion	☐	☐	Cancer Treatment	☐	☐	Cosmetic Surgery (Facial)
☐	☐	Diabetes	☐	☐	Dizziness/ Fainting	☐	☐	Drug Addiction
☐	☐	Epilepsy/ Seizures	☐	☐	Hear Loss/ Deaf	☐	☐	Heart Disease
☐	☐	Heart Murmur	☐	☐	Pacemaker	☐	☐	Heart Surgery
☐	☐	Hepatitis B or C	☐	☐	Herpes/ Fever Blister	☐	☐	High Blood Pressure
☐	☐	Kidney Problem	☐	☐	Liver Disease	☐	☐	Mitral Valve Prolapse
☐	☐	Narcotic Allergy	☐	☐	Nervous Disorder	☐	☐	Psychiatric Treatment
☐	☐	Respiratory Problems	☐	☐	Rheumatic/ Scarlet Fever	☐	☐	Seasonal Allergies
☐	☐	Sinus Trouble	☐	☐	Sjogren's Syndrome	☐	☐	Sleep Apnea
☐	☐	STD	☐	☐	Stroke	☐	☐	Sulfa Allergy
☐	☐	Thyroid Disease	☐	☐	Tuberculosis	☐	☐	Ulcers

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

Yes	No		Yes	No		Yes	No	
☐	☐	Local Anesthetic	☐	☐	Percocet	☐	☐	Latex
☐	☐	Penicillin/Amoxicillin	☐	☐	Erythromycin	☐	☐	Valium
☐	☐	Nitrous Oxide	☐	☐	Fluoride	☐	☐	Iodine
☐	☐	Other Antibiotic Allergy	☐	☐	Codeine	☐	☐	Aspirin

Allergy to other medications, substances or metals? _____

Our office is dedicated to the concept that all people should have the opportunity to retain their natural teeth for a lifetime. Preventive measures, high quality care and good cooperation, combined with timely treatment, make it possible for most people to retain their natural teeth with optimum comfort, function, and appearance. My staff and I are dedicated to this concept and with your cooperation; we will do everything we can to help you reach your goals for dental health.

_____ _____

Signature Date

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DENTAL HSTORY

Complete answers to the following questions will allow you to be treated on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

Are you having any dental discomfort at this time? ☐ Yes ☐ No If yes, please explain_____

Have you ever had any serious trouble associated with previous dentistry? ☐ Yes ☐ No
If yes, please explain _____

Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

Date of last dental visit? _____ Dentist Name _____
Address _____ Phone Number _____

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ☐ Yes ☐ No
If yes, please explain _____

Do you have or have you ever had any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Biting cheek/lips	☐	☐	Loose Teeth	☐	☐	Dentures
☐	☐	Clicking/Popping Jaw	☐	☐	Sensitive to Hot	☐	☐	Partials
☐	☐	Difficulty opening /closing jaw	☐	☐	Sensitive to Cold	☐	☐	Bleeding, sore gums
☐	☐	Headaches, earaches, neck pain	☐	☐	Sensitive to Sweets	☐	☐	Unpleasant taste/bad breath
☐	☐	Clenching/ Grinding	☐	☐	Sensitive to Biting	☐	☐	Burning Tongue/ Lips
☐	☐	Shifting in Bite	☐	☐	Sensitive to Chewing	☐	☐	Swelling/ Lumps in Mouth
☐	☐	Change in Bite	☐	☐	Food Impaction	☐	☐	Ortho Treatment (braces)
☐	☐	Do you wear a night guard	☐	☐	Do you use tobacco product?	☐	☐	Snoring
☐	☐	Fatigue/ Sleepiness during the day						

These are the things that are important to me about my dental health:_____
_____

What do you fear the most about dental care? _____

Check one:

1. My mouth is ☐ very comfortable ☐ moderately comfortable ☐ uncomfortable
2. ☐ I think the appearance of my mouth is excellent ☐ I am satisfied with the appearance of my mouth
   ☐ I am dissatisfied with the appearance of my mouth
3. ☐ I will do anything to keep my natural teeth ☐ I want to keep my teeth, but have certain budget of time and money that I am will to spend on them.
4. ☐ I have always done the best that was recommended for my dental health.
   ☐ I have not done what dentists have recommended to me.
   ☐ I rarely, go and don't care much about having any dental work complete.
5. ☐ I have put dentistry for myself and family high on my priority list
   ☐ I have put dentistry for myself and family low on my priority list.
   ☐ I have dentistry on my list but it's hard to find the time

I think my state of dental health is ☐ excellent ☐ Good ☐ Poor

Please PRIORITIZE the following in the order in which they would KEEP YOU FROM having dental treatment. Please number 1-4. With 1 being the highest priority

____ Fear of Pain ____Lack of Concern ____ Cost of Treatment ____ Missing work time

What are some questions about dentistry and oral health that you have never had adequately answered? _____
_____

_____ _____

Signature Date