Hamilton Town Dentistry
Patient Registration

1

Personal Information

Name:
Parent's Name (if child):
Address:
City: State: Zip:
Home Phone: Cell Phone:
Birthdate:
Social Security Number:
Email address:
Place of Employment
Work Phone:

2

Dental Insurance

Insurance Company:
Group #
Insured's information (if different than at left)
Name:
SSN:
Birthdate:
Employer:

3

Important Contacts

In Case of Emergency contact:
Relation:
Home Phone:
Work Phone:
Address:
City: State: Zip:
Who Referred You to Our Office?

4

Dental History

Do you have a specific dental problem? Yes No
If so, what?

Do you feel nervous about having dental treatment? Yes No

Are your teeth sensitive to hot, cold, sweets, pressure? Yes No
If yes, please circle all that apply.

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

Please rank the following in the order in which they would keep you from receiving dental care:

Fear of pain _____ Lack of concern _____

Cost of treatment _____ Missing work time _____

Consent for Treatment

The undersigned hereby authorizes the doctors and/or staff at Hamilton Town Dentistry to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctors to make a thorough diagnosis of the patient's dental needs. I also authorize the doctors to perform any and all forms of treatment, medication and therapy, which may be indicated and further authorize and consent that the doctors choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I also assign all insurance benefits to the practice. Any payments received by the practice from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. We understand things come up, but kindly ask for a 48 hour notice of cancellation. I understand that if I cancel within 24 hours of my scheduled appointment, a cancellation fee of $40 will be assessed.

Patient Signature (Parent of Child): _____ Date_____ Witness: _____

Patient Name: Hamilton Town Dentistry Health History

Sex M F Height_____ Weight_____ Single_____ Married_____

Do you have any current health problems?……..……Yes No
Have you been hospitalized in the past 5 years?……...Yes No
Are you currently under the care of a physician?……..…… Yes No

Physician's Name:_____ Phone #_____

Address_____

Please explain any 'yes' answers from left:

For the following 32 questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

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

1. Damaged heart valves, including heart murmur, mitral valve prolapse or rheumatic heart disease?……Yes No
2. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency coronary occlusion, high or low blood pressure, arteriosclerosis, stroke)……..Yes No
   a. Do you have chest pains upon exertion?…….. Yes No
   b. Are you ever short of breath after mild exercise or when lying down?……Yes No
   c. Do your ankles swell?…….…….. Yes No
   d. Do you have inborn heart defects?……Yes No
   e. Do you have a cardiac pacemaker?…….….. Yes No
3. Allergy…….…….. Yes No
4. Sinus trouble…….. Yes No
5. Asthma or Hay Fever…… Yes No
6. Fainting spells or seizures……..Yes No
7. Persistent diarrhea or recent weight loss……Yes No
8. Diabetes……..Yes No
9. Hepatitis, jaundice, or liver disease…….…….. Yes No
10. AIDS or HIV infection…….…. Yes No
11. Thyroid problems…….……...Yes No
12. Osteoporosis……...Yes No
13. Respiratory problems, emphysema, bronchitis, etc…… Yes No
14. Arthritis or painful, swollen joints…… Yes No
15. Joint replacement surgery…….. Yes No
16. Stomach ulcer or hyperacidity……... Yes No
17. Kidney Trouble…….. Yes No
18. Tuberculosis…….……...Yes No
19. Persistent cough or cough that produces blood……..Yes No
20. Persistent swollen glands in neck…..…… Yes No
21. Sexually transmitted disease……..Yes No
22. Epilepsy or other neurological disease…….. Yes No
23. Problems with mental health……. Yes No
24. Cancer..……..Yes No
25. Treatment for a tumor growth…….…….. Yes No
26. Radiation or chemotherapy……Yes No
27. Problems of immune system…… Yes No
28. Abnormal bleeding……Yes No
29. Any blood disorder such as anemia……... Yes No
30. Drug dependency……... Yes No
31. Do you use tobacco……Yes No
32. Women:
    a. Are you pregnant?……Yes No
    b. Are you nursing?…….……. Yes No
    c. Are you taking birth control pills?…… Yes No

Are you allergic or have you had a reaction to any of the following medications or materials: Yes (circle which) No

Aspirin	Penicillin	Local Anesthetic
Codeine	Erythromycin	Novocaine
Vicodin	Tetracycline	Xylocaine
Sulfa drugs	Latex	Acrylic

Are you allergic to any other medications? Yes No
If so, what?_____

Please list all medications, drugs, and pills (including non-prescription) which you are now taking or have taken in the past two years. If you have *ever* taken a bisphosphonate, please list that, as well:

Do you have any disease, condition, or problem not listed above that you think Dr. Hopkinson or Dr. Sullivan should know about? Yes No
If so, please explain:_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold the doctors or any of the staff responsible for any errors or omissions that I may have made in the completion of this form. If I have any changes in my health status or if my medications change, I will inform the doctor and his staff at the next appointment.

Patient Signature (Parent of child)_____Date:_____

Reviewed by Dr. Hopkinson/Sullivan:

Date:

Notes:

Hamilton Town Dentistry

Dental History Form

Patient Name:_____ Date:_____

What is the main reason for your visit today?		
Date of Last Dental Visit:	Date of Last Dental Cleaning:	Date of Last Dental X-rays:

1. Do you have any dental concerns at this time? Yes No

   If so, please explain:_____

2. How often you do you have dental examinations? _____

   _____

3. Have you ever had:

   a. Orthodontic treatment Yes No

   b. Oral surgery Yes No

   c. Periodontal treatment Yes No

   d. Your bite adjusted Yes No

   e. A bite plate or mouth guard Yes No

   f. A serious injury to the mouth or head? Yes No

   If yes, please describe _____

   _____

4. TMJ.

   Have you ever experienced:

   a. *Clicking* of the jaw? Yes No

   b. Difficulty in *opening or closing*? Yes No

   c. Difficulty in *chewing*? Yes No

5. Habits.

   Do you:

   a. Clench or grind your teeth? Yes No

   b. Bite your lips or cheeks regularly? Yes No

   c. Hold foreign objects with your teeth?

   (pencils, pipes, pins, nails, fingernails) Yes No

   d. Have tired jaws, especially in the morning? Yes No

   c. How often do you:

   brush _____ floss _____

   d. What other dental aids do you use? _____

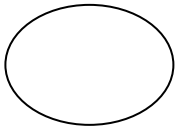
6. Does food ever get caught between any of your teeth? Yes No

7. Do you suffer from bleeding or swelling in your gums? Yes No

8. Are you dissatisfied with the appearance of your teeth? Yes No

9. On a scale of 1-10, how would you rate your teeth?

   (1 being the worst, 10 being the best)



10. Do you feel nervous about dental treatment? Yes No

    If so, what is your biggest concern _____

    _____

11. Have you ever had an upsetting dental experience? Yes No

    If so, please describe _____

    _____

Is there anything else about having dental treatment that you would like us to know? _____

_____

HAMILTON TOWN DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT:

Name: _____
Address: _____ City: _____ State: ____ Zip: _____
Telephone: _____ Social Security #: _____

SECTION B: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at (317) 773-9992 or by mailing us at 14139 Town Center Boulevard, Suite 200, Noblesville, IN 46060.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this Consent will not affect any action we took before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, please complete the following.

Personal Representative's Name: _____ Relationship: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.