Jon L. Hardinger
DDS
General Dentistry

Welcome to Our Practice

Date # _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Soc. Sec. # _____ Male ☐ Female ☐
Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's Employer _____ Work Phone _____
Cell Phone _____ Email _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Soc. Sec. # _____
Employer _____ Work Phone _____
If Patient is a Student, Name of School / College _____ City _____ State _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone _____

Responsible Party (IF DIFFERENT FROM ABOVE)

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Soc. Sec. # _____ Birthdate _____ Home Phone _____
Employer _____ Work Phone _____
Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Dental Insurance Information (PLEASE PRESENT CARD)

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____

Dental Health Goals

Would you like whiter teeth? _____
Is there anything you would like to change about your smile? _____
How do you feel about maintaining a healthy mouth? _____

Over Please

Patient Medical History

Medical Physician _____ Date of Last Exam _____

Other Healthcare Providers _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
If yes, please list _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
Name of Pharmacy _____		
4. Do you use tobacco? (e.g. smoking or chewing)	☐	☐
5. Are you wearing contact lenses?	☐	☐
6. Are you taking vitamins or supplements?	☐	☐

7. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (e.g. novocaine)	☐	☐
Penicillin	☐	☐
Sulfa Drugs	☐	☐
Aspirin	☐	☐
Latex	☐	☐
Nickel	☐	☐
Other	☐	☐
8. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

9. Have you had any of the following?

	Yes
Hearing Impairment	☐
Infectious Diseases	☐
Behavioral / Mental Condition	☐
Alcohol Abuse	☐
Substance Abuse	☐
Methamphetamine Abuse	☐
High Blood Pressure	☐
Low Blood Pressure	☐
Seizures / Fainting Spells	☐
Epilepsy / Convulsions	☐
Asthma	☐
Hay Fever / Allergies	☐
Respiratory Problems	☐

	Yes
Diabetes Type I or II	☐
Kidney Diseases	☐
Thyroid Problem	☐
Sinus Problems	☐
Sexually Transmitted Disease	☐
AIDS or HIV Infection	☐
Cardiac Pacemaker	☐
Heart Murmur	☐
Angina	☐
Stroke	☐
Cancer	☐
Date: _____	
Leukemia	☐

	Yes
Radiation Therapy	☐
Arthritis	☐
Joint Replacement or Implant	☐
Date: _____	
Hepatitis / Yellow Jaundice	☐
Liver Disease	☐
Anemia	☐
Stomach Trouble / Ulcers	☐
Acid Reflux	☐
Bleeding Disorders / Bruising	☐
Tuberculosis	☐
Persistent Cough	☐
Recent Weight Loss	☐
Are you taking blood thinners	☐
Other	☐

Patient Dental History

10. Have you had any of the following Dental problems?	Yes
Bleeding Gums while brushing or flossing	☐
Sensitive Teeth to hot, cold, sweet, sour	☐
Tooth Pain	☐
Level of pain: Scale 1-10 _____	
Lumps or Sores in or near your mouth	☐
Head, Neck or Jaw Injuries	☐
Jaw Problems:	☐
Clicking	☐
Pain (joint, ear, side of face, neck)	☐
Difficulty in chewing	☐
Dry Mouth	☐
Bad Breath	☐
11. Does food get stuck between your teeth?	☐
12. Do you request no anesthetic? (i.e. novocaine)	☐
13. Would you like to have nitrous oxide? (i.e. laughing gas)	☐

	Yes	No
14. Do you or have you ever worn a tongue bar?	☐	☐
15. Does being set back in the dental chair bother you?	☐	☐
16. Are you a fearful patient?	☐	☐
17. Do you have frequent headaches?	☐	☐
18. Do you clench or grind your teeth?	☐	☐
19. Do you bite your lips or cheeks frequently?	☐	☐
20. Have you ever had any difficult extractions in the past?	☐	☐
21. Have you ever worn braces on your teeth?	☐	☐
22. Have you ever had any prolonged bleeding following extractions?	☐	☐
23. Have you ever had homecare instructions on how to care for your teeth and gums?	☐	☐
24. Would you like to have XM music with headphones?	☐	☐

Name of Previous Dentist _____ Date of Last Dental Exam _____

Authorization, Release and Handling Fee

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the 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. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. ***A monthly $6 handling fee is added to any account over 90 days old and to an account that is not paid as agreed upon.***

X _____

Signature of patient or parent if minor