WILLIAM B. HAMEL III, D.D.S.

========== = *Comprehensive Dentistry* ==========

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PATIENT INFORMATION

Today's Date:

Name: MR MRS MS DR_____ **Greeting Name:** _____
Last First M.I. SUFFIX

Date of Birth:____/___/_____

Social Security# _____ ☐ Male ☐ Female

Address:_____ **City:**_____ **State:**_____ **Zip:** _____

Home Phone_____ **Cell#**_____ **Work#**_____ **Preferred#** Home ☐ Cell ☐ Work ☐

Email:_____ **Student?** Yes ☐ No ☐ School:_____ City: _____

Emergency Contact:_____

Relation:_____ Hm#_____ Cell# _____

How Did You Hear About Us? (We Would Like To Thank Them) _____

RESPONSIBLE PARTY

☐ **Same As Above**

Name: _____

Relation: _____ **Social Security#** _____

Address:_____ **City:**_____ **State:**_____ **Zip:** _____

INSURANCE INFORMATION

Ins. Company Name:_____ **Phone#**_____ **Group#** _____

Ins. Address:_____ **City:**_____ **State:**_____ **Zip:** _____

Subscriber Name:_____ **ID#**_____ **Relation:** _____

Social Security# _____

Date of Birth____/ _/_____ ☐Single ☐ Married ☐ Divorced ☐
☐Widowed ☐ Separated

Subscriber Employer:_____ **Employer tK2yŜ** _____

Employer Address:_____ **City:**_____ **State:**_____ **Zip:** _____

SECONDARY INSURANCE? Yes ☐ No ☐

Ins. Company Name:_____ **Phone#**_____ **Group#** _____

Ins. Address:_____ **City:**_____ **State:**_____ **Zip:** _____

Social Security# _____

Date of Birth___/ _/_____ ☐Single ☐ Married ☐ Divorced ☐
☐Widowed ☐ Separated

Subscriber Employer: _____

Employer Phone#_____

Employer Address:_____ **City:**_____ **State:**_____ **Zip:** _____

DENTAL HISTORY

Name of Previous Dentist and Location: _____ **Date of Last Exam:** _____

	YES	NO
Do your gums bleed while brushing/flossing?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
Do you have pain in any of your teeth?	☐	☐
Do you have any sores or lumps in or around your mouth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you ever experienced any of the following problems in your jaw?		
Clicking?	☐	☐
Pain (joint, ear, side of face)?	☐	☐
Difficulty in opening or closing?	☐	☐
Difficulty in chewing?	☐	☐

	YES	NO
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you had any difficult extractions?	☐	☐
Have you had prolonged bleeding after extraction?	☐	☐
Have you had any orthodontic treatment?	☐	☐
Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
Do you like your smile?	☐	☐

MEDICAL HISTORY

Physician: _____ **Office Phone:** _____ **Date of Last Exam:** _____

	YES	NO	
Are you under a physician's treatment now?	☐	☐	If yes, please explain _____
Have you ever been hospitalized, had a major operation or a serious illness?	☐	☐	If yes, please explain _____
Have you ever had a serious head or neck injury?	☐	☐	If yes, please explain _____
Are you taking any medication(s) including non-prescriptions?	☐	☐	If yes, please list _____
Do you need to be Pre-Medicated before your appointment?	☐	☐	If yes, why? -----_____
Have you ever taken Fosomax, Boniva, Actonel or any other medications containing bisphosphonates?	☐	☐	_____ If yes, please list _____
Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐	If yes, please explain _____
Do you have a persistant cough or throat clearing not assocated with a known illness? (lasting longer than 3 weeks)	☐	☐	If yes, please explain _____

Are you on a special diet? ☐ Yes ☐ No Do you use tobacco? ☐ Yes ☐ No Do you use controlled substances? ☐ Yes ☐ No

FOR WOMEN: Are you Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following? Aspirin ☐ Penicillin or other antibiotics ☐ Local Anaethetics (e.g. Novacaine) ☐ Sulfa drugs ☐
Codeine ☐ Barbiturates ☐ Sedatives ☐ Iodine ☐ Metals ☐ Acrylic ☐ Latex ☐ Other ☐ Please explain _____

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

AIDS/HIV Positive ☐	Cortisone Medicine ☐	Hemophilia ☐	Radiation Treatments ☐
Alzheimer's Disease ☐	Diabetes ☐	Hepatitis A ☐	Recent Weight Loss ☐
Anaphylaxis ☐	Drug Addiction ☐	Hepatitis B or C ☐	Renal Dialysis ☐
Anemia ☐	Easily Winded ☐	Herpes ☐	Rheumatic Fever ☐
Angina ☐	Emphysema ☐	High Blood Pressure ☐	Rheumatism ☐
Arthritis/Gout ☐	Epilepsy or Seizures ☐	High Cholesterol ☐	Scarlet Fever ☐
Artificial Heart Valve ☐	Excessive Bleeding ☐	Hives or Rash ☐	Shingles ☐
Artificial Joint ☐	Excessive Thirst ☐	Hypoglycemia ☐	Sickle Cell Disease ☐
Asthma ☐	Fainting Spells ☐	Irregular Heartbeat ☐	Sinus Trouble ☐
Blood Disease ☐	Frequent Cough ☐	Kidney Problems ☐	Spina Bifida ☐
Blood Transfusion ☐	Frequent Diarrhea ☐	Leukemia ☐	Stomach/Intestinal Disease ☐
Breathing Problems ☐	Frequent Headaches ☐	Liver Disease ☐	Stroke ☐
Bruise Easily ☐	Genital Herpes ☐	Low Blood Pressure ☐	Swelling of Limbs ☐
Cancer ☐	Glaucoma ☐	Lung Disease ☐	Thyroid Disease ☐
Chemotherapy ☐	Hay Fever ☐	Mitral Valve Prolapse ☐	Tonsillitis ☐
Chest Pains ☐	Heart Attach/Failure ☐	Osteoporosis ☐	Tuberculosis ☐
Cold Sores/Fever Blisters ☐	Heart Murmur ☐	Pain In Jaw Joints ☐	Tumors or Growths ☐
Congenital Heart Disorder ☐	Heart Pacemaker ☐	Parathyroid Disease ☐	Ulcers ☐
Convulsions ☐	Heart Trouble/Disease ☐	Psychiatric Care ☐	Venereal Disease ☐
Other Illness Not Listed ☐ _____			Yellow Jaundice ☐

AUTHORIZATION AND RELEASE

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 and request my insurance company to pay the dentist directly for 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 and those of my dependents.

Signature of Patient (or parent/guardian of minor): _____ Date: _____