Hampton Dental Patient Information and Consent Form

Chart #:_____ Dentist:_____ Date:_____

Name: _____
Date of Birth: _____
Home #: _____
Cell #: _____
Work #: _____
Email Address: _____
Emergency Contact Name: _____
Emergency Contact #: _____
Person Responsible for account if not Self:

_____

Signature _____

Who can we thank for referring you to our office?

_____

What would your long term goals regarding the condition of your teeth and mouth be?

_____
_____
_____

Yes / No Do you ever wake up with headaches?
Yes / No Are you aware if you grind or clench?
Yes / No Is it difficult to open and close?
Yes / No Has any dentist adjusted your bite? _____
_____
Yes / No Have you noticed any teeth becoming loose?
_____
Yes / No Is there an area where food always become caught?
_____
Yes / No Do you experience an unusually bad taste at times?
_____
Yes / No Is there often bleeding when you floss or brush?

Some medications and health conditions can affect oral health and complicate dentistry. A medical history is important.

Yes / No Do you believe you are in good health?
_____
_____
Yes / No Have you seen a medical doctor in the past year?
Reason: _____
_____
_____
Yes / No Do you have allergies to medication or anesthetics?
_____
_____
_____
Yes / No Are you currently taking any medications of any kind, including non-prescription?

PLEASE LIST EACH MEDICATION BELOW

_____
_____
_____
_____
_____
_____
_____

Yes / No Have you reason to believe you are pregnant?

Yes / No Have you had surgery involving transplants or joint replacements? _____
_____
_____
_____

Yes / No Has **PREMEDICATION** been prescribed for past dentistry?
Reason _____
_____
_____

Yes / No Any Heart related medical issues?
_____
_____
_____

Yes / No Have you had any of the following:

Cancer ( ) Chemo ( ) Radiation ( )

Yes / No Do you have High ( ) Low ( ) blood pressure?
Yes / No Do you have stomach ulcers?
Yes / No Have you had a stroke?
Yes / No Do you have diabetes? diet ( ) medication ( )
Yes / No Do you have epilepsy?
Yes / No Are you prone to fainting spells?
Yes / No Do you bruise unnecessarily or bleed for prolonged periods?
Yes / No Do you have asthma? ventilator ( ) inhaler ( )
Yes / No Do you have chronic cold sores or canker sores?
Yes / No Hepatitis? Type _____ Recent Blood Test _____
Yes / No HIV Positive?
Yes / No Lung Disease ( ) tuberculosis ( ) thyroid ( )
Yes / No Do you smoke?
Yes / No Any Conditions not listed above: _____
_____
_____
_____

Our office uses state of the art digital x-ray equipment. X-rays are essential to provide a complete exam and diagnose underlying conditions.

I ( ) do ( ) do not authorize all necessary dental x-rays. I understand that should I refuse x-rays, the dentist will not be held responsible for any problems that may occur as a result of this decision.

****I understand the questions on this form directly relate to the quality of dental care I can expect to receive in this office, and I have not knowingly withheld information that could complicate my treatment.***

****I also understand it is my responsibility to be aware of my Dental Policy & Coverage. I understand that I am financially responsible to Sussex Dental Clinic and/or Hampton Dental Clinic for any treatment or claim that is not covered or may exceed my Plan Benefits.***

Patient Signature: _____

Date: _____