Hylan DENTAL CARE

Member: ADA, ODA, Cleveland Dental Society, Nat. Honor Society, Phi Eta Sigma Honor Society, Summa Scholarship Society, Alpha Omega.

Part 1: PATIENT INFORMATION

Name_____ Address_____ E-Mail _____

City_____ State_____ Zip_____ **Birth Date**_____ Sex _____

Home Phone_____ Cell Phone_____Employer_____

Soc. Sec. #_____ Spouse's Name_____ Student? ____ If yes, which school?_____

Emergency Contact Name _____ Phone Number_____ Relation _____

Part 2: INSURANCE INFORMATION

If you would like to use your dental insurance, please fill out the following and sign:

Insured's Name_____ **Insured's Soc. Sec. #** _____Insurance Co. _____

Insured's relationship to patient _____ **Insured's date of birth** _____ Insured's Employer_____

I authorize payment directly to Hylan Dental Care, and any portion of my bill not covered by insurance is my responsibility!

Payment is expected at the time services are rendered. We accept cash, MasterCard, Visa, Discover, debit cards, and dental insurance. We also have 2 types of payment plans available. If you would like to apply for either, please let us know!!!

SIGNATURE _____ **DATE** _____

Part 3: DENTAL QUESTIONS

How can we help you? _____ **How did you hear about our office?** _____

If you found our office on the internet, what category, terms and words did you search under? _____

Were you satisfied with your past dental treatment? _____ If not, why? _____

How would you describe a good dentist? _____

Are you pleased with the appearance of your teeth? Yes / No If no, what would you change? _____

Would you like whiter teeth? Yes / No Do your gums ever bleed? Yes / No

How would you describe your present dental health? _____

_____

_____

_____

SIGNATURE_____ **DATE**_____

Part 4: HIPPA ACKNOWLEDGEMENT

I acknowledge that I have read the HIPPA policies of Hylan Dental Care. Hylan Dental Care has answered all of my questions concerning their legal policies, healthcare operations, patient rights, and defamation practices. I understand that I may request a copy of these policies at any time. I agree to the terms they have set forth and I would like to begin treatment with them as their patient.

SIGNATURE_____ **DATE**_____

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Part 5: MEDICAL HISTORY

Name_____ Birth Date_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care right now? ○Yes ○No If yes, please explain _____

Have you ever been hospitalized or had a major operation? ○Yes ○No If yes, please explain _____

Have you ever had a serious head or neck injury? ○Yes ○No If yes, please explain _____

Are you taking any medications, pills or drugs? ○Yes ○No If yes, please explain_____

Do you take, or have you taken, Phen-Fen or Redux? ○Yes ○No If yes, please explain_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○Yes ○No 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

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 ○Codeine ○Local Anesthetics ○Sulfa drugs ○Acrylic ○Latex ○Metal ○Other

If yes, please explain _____

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

AIDS/HIV Positive ○Yes ○No	Cortisone Medicine ○Yes ○No	Hemophilia ○Yes ○No	Radiation Treatments ○Yes ○No
Alzheimer's Disease ○Yes ○No	Diabetes ○Yes ○No	Hepatitis A ○Yes ○No	Recent Weight Loss ○Yes ○No
Anaphylaxis ○Yes ○No	Drug Addiction ○Yes ○No	Hepatitis B or C ○Yes ○No	Renal Dialysis ○Yes ○No
Anemia ○Yes ○No	Easily Winded ○Yes ○No	Herpes ○Yes ○No	Rheumatic Fever ○Yes ○No
Angina ○Yes ○No	Emphysema ○Yes ○No	High Blood Pressure ○Yes ○No	Rheumatism ○Yes ○No
Arthritis/Gout ○Yes ○No	Epilepsy or Seizures ○Yes ○No	High Cholesterol ○Yes ○No	Scarlet Fever ○Yes ○No
Artificial Heart Valve ○Yes ○No	Excessive Bleeding ○Yes ○No	Hives/Rash ○Yes ○No	Shingles ○Yes ○No
Artificial Joint ○Yes ○No	Excessive Thirst ○Yes ○No	Hypoglycemia ○Yes ○No	Sickle Cell Disease ○Yes ○No
Asthma ○Yes ○No	Fainting Spells/Dizziness ○Yes ○No	Irregular Heartbeat ○Yes ○No	Sinus Trouble ○Yes ○No
Blood Disease ○Yes ○No	Frequent Cough ○Yes ○No	Kidney Problems ○Yes ○No	Spina Bifida ○Yes ○No
Blood Transfusion ○Yes ○No	Frequent Diarrhea ○Yes ○No	Leukemia ○Yes ○No	Stomach/Intestinal Disease ○Yes ○No

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Breathing Problem ○Yes○No	Frequent Headaches ○Yes○No	Liver Disease ○Yes○No	Stroke ○Yes○No
Bruise Easily ○Yes○No	Genital Herpes ○Yes○No	Low Blood Pressure ○Yes○No	Swelling of Limbs ○Yes○No
Cancer ○Yes○No	Glaucoma ○Yes○No	Lung Disease ○Yes○No	Thyroid Disease ○Yes○No
Chemotherapy ○Yes○No	Hay Fever ○Yes○No	Mitral Valve Prolapse ○Yes○No	Tonsillitis ○Yes○No
Chest Pains ○Yes○No	Heart Attack/Failure ○Yes○No	Osteoporosis ○Yes○No	Tuberculosis (TB) ○Yes○No
Cold Sores/Fever Blisters ○Yes○No	Heart Murmur ○Yes○No	Pain in Jaw Joints ○Yes○No	Tumors or Growths ○Yes○No
Congenital Heart Disorder ○Yes○No	Heart Pacemaker ○Yes○No	Parathyroid Disease ○Yes○No	Ulcers ○Yes○No
Convulsions ○Yes○No	Heart Trouble/Disease ○Yes○No	Psychiatric Care ○Yes○No	Venereal Disease ○Yes○No
			Yellow Jaundice ○Yes○No

Have you ever had any serious illness not listed above? ○Yes○No _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE of Patient, Parent or Guardian_____

DATE_____

Comments:

_____

_____