PATIENT INFORMATION

Patient Name: ______________________________ ☐ Male ☐ Female
Last First MI

Social Security # ____________________ Birth Date: ____________ Age: ________

Cell #: ______________ Home #: ______________ Work #: ______________

Email: ______________________________

Address: ______________________________
Street Apartment #

____
City State Zip

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for: ☐ **Patient's Spouse** ☐ **Person Responsible for Payment** ☐ Male ☐ Female

Name: ______________________________ Birth Date: ____________
Last First MI

☐ Married ☐ Single ☐ Other ____________ Employer Name & Address: ______________________________

Social Security # ____________________

Cell #: ______________ Home #: ______________ Work #: ______________

Email: ______________________________

Address: ______________________________
Street Apartment #

____
City State Zip

DENTAL INSURANCE INFORMATION

Dental Ins Co: ______________________________ Group #: ______________

Subscriber (Name on Card): ______________________________ Subscriber's Birth Date: ______________
Last First MI

Subscriber's Employer: ______________________________ Subscriber's SS#: ______________

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Newspaper ☐ School ☐ Work ☐ Other: ______________

Name of person or office referring you to our practice: ______________________________

CONSENT FOR SERVICES

1) I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.
2) Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3) I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies a certain risk. I understand that I can ask for a complete recital on any possible complication.
4) I agree to be responsible for payment of all services on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a $25 late charge may be added to my account.
5) I hereby give Dr. Jason Hartman the absolute right and permission to use my photographs/slides for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs/slides.

______________________ | ______________________ | ______________
Signature of Patient / Parent / Guardian | Print Name | Date

DENTAL HISTORY

Name of Dentist? ______________________________ Dentist's Phone #: ____________

Date of Last Dental Cleaning/Examination: ____________ How often do you have a Dental Cleaning/Examination? ____________

1. Have you ever had orthodontic treatment or consult? ☐Yes ☐No If yes, when and where? ____________
2. Have you ever seen a periodontist or been treated for gum disease? ☐Yes ☐No If yes, when and where? ____________
3. Has your bite ever been adjusted? ☐Yes ☐No
4. Are your teeth sensitive? ☐Yes ☐No
5. Do/Did you suck your thumb? ☐Right ☐Left Does habit continue? ☐Yes ☐No *OR* What age did habit stop? ______
6. Do you ☐ clench or ☐ grind your teeth? If checked, do you do this: ☐All the time ☐Only at night ☐Only when nervous/stressed
7. Do your gums bleed? ☐Yes ☐No If yes, do gums bleed: ☐All the time ☐Occasionally
8. Have you noticed any mouth odors or bad tastes? ☐Yes ☐No
9. Does food tend to become caught between your teeth? ☐Yes ☐No
10. Do you have clicking or popping in your jaw? ☐Yes ☐No
11. Do you have difficulty opening or closing your mouth? ☐Yes ☐No
12. Have you been told you have a TMJ problem? ☐Yes ☐No
13. Do you get frequent headaches? ☐Yes ☐No
14. Would you like to keep your teeth all your life? ☐Yes ☐No
15. Have you noticed any loose teeth or change in your bite? ☐Yes ☐No If yes, pls explain: ____________
16. Have you ever had an injury to the face or teeth? ☐Yes ☐No If yes, pls explain: ____________
17. Do you feel nervous about having dental treatment? ☐Yes ☐No If yes, pls explain: ____________
18. Have you ever had an upsetting dental experience? ☐Yes ☐No If yes, pls explain: ____________
19. Have you had any complications following dental treatment? ☐Yes ☐No If yes, pls explain: ____________
20. Are you happy with the appearance of your teeth? ☐Yes ☐No If no, pls explain: ____________

MEDICAL INFORMATION

Name of Physician? ______________________________ Physician's Phone #: ____________

Have you ever had any of the following? Please check those that apply

☐ AIDS	☐ Blood Disease	☐ Hay Fever	☐ Pacemaker	☐ Stroke
☐ Allergy to Latex	☐ Bone Disorders	☐ Head Injuries	☐ Pre-Medication Required	☐ Tuberculosis
☐ Allergy to Nickel	☐ Cancer	☐ Heart Disease	☐ Pregnancy	☐ Tumors
☐ Allergy to Plastic	☐ Diabetes	☐ Heart Murmur	-Due Date__________	☐ Ulcers
☐ Allergy to Codeine	☐ Dizziness	☐ Hepatitis	☐ Radiation Treatment	☐ Venereal Disease
☐ Allergy to Penicillin	☐ Epilepsy	☐ High Blood Pressure	☐ Respiratory Problems	**Current Medications:**
☐ Anemia	☐ Excessive Bleeding	☐ Jaundice	☐ Rheumatic Fever	☐ __________
☐ Arthritis	☐ Fainting	☐ Kidney Stones	☐ Rheumatism	☐ __________
☐ Artificial Joints	☐ Glaucoma	☐ Liver Disease	☐ Sinus Problems	☐ __________
☐ Asthma	☐ Growths/Cysts	☐ Mental Disorders	☐ Stomach Problems	☐ __________

1. Have you ever been admitted to a hospital or needed emergency care during the past two years? ☐Yes ☐No If yes, pls explain: ____________
2. Are you now under the care of a physician? ☐Yes ☐No If yes, pls explain: ____________
3. Do you have any health problems that need further clarification? ☐Yes ☐No If yes, pls explain: ____________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of Patient / Parent / Guardian	Print Name	Date

CONFIDENTIAL MEDICAL DENTAL HISTORY

Dr. Jason Hartman & Associates