WILLIAMSBURG CENTER for Dental Health

Stacey Sparkman Hall, D.D.S

Patient Information

Patient Name: _____ Date: _____

Last First MI (Preferred Name)

Social Security #:_____ Gender:_____ Birth Date:_____

Phone (Home):_____ (Work):_____ Ext:_____ (Cell):_____

Address:_____

Street Apartment #

_____

City State Zip Code

Email:_____

Preferred Method of Contact: ☐ Email ☐ Home Ph. ☐ Cell Ph. ☐ Work Ph.

Emergency Contact:_____ Phone:_____

Responsible Party and Insurance Information

The following is for: ☐ the person responsible for payment ☐ the policy holder

Name:_____ Relationship to patient:_____

Last First MI (Preferred Name)

Dental Insurance Company:_____

Subscriber ID:_____ Insurance Co. Phone #:_____

Pharmacy Information

Pharmacy Name:_____ Pharmacy Phone:_____

Medical Information *(copy of card)*

Health Insurance Company:_____ Group #:_____

Subscriber ID:_____ Insurance Co. Phone #:_____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another Patient ☐ Dental Office

☐ Website:_____ ☐ Newpaper ☐ Work ☐ Other:_____

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

Consent for Services

1) I herby 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. *Initial*_____

2) Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. *Initial*_____

3) I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital on any possible complication. *Initial*_____

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 7% late charge may be added to my account. *Initial*_____

5) I herby give the doctor the absolute right and permission to use my photograph/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. *Initial*_____

6) I acknowledge that I reviewed the Williamsburg Center for Dental Health's HIPAA and Notice of Privacy Practices. A copy is available upon request. *Initial*_____

7) I give permission to email or text appointment reminders and other information. *Initial*_____

_____ _____ _____

Signature of Patient Date Relationship to Patient

Williamsburg Center for Dental Health asks that all patients carefully take the time to fully complete this medical and dental history informational sheet. Our office is dedicated to providing complete dentistry for your well-being. It is important that we are provided with as much information as possible.

Medical Information

Have you or any family members had any of the following? Please check all that apply:

Self	Family		Self	Family		Self	Family		Self	Family	
☐	☐	AIDS	☐	☐	Drug use	☐	☐	HPV	☐	☐	Rheumatism
☐	☐	Alcohol use	☐	☐	Ear problem	☐	☐	High Blood Pressure	☐	☐	Sinus Problems
☐	☐	Anemia	☐	☐	Eating Disorders	☐	☐	Jaundice	☐	☐	Stomach Problems
☐	☐	Arthritis	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Stroke
☐	☐	Artificial Joints	☐	☐	Excessive Bleeding	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Fainting	☐	☐	Mental Disorders	☐	☐	Tumors
☐	☐	Blood Disease	☐	☐	Glaucoma	☐	☐	Nervous Disorders	☐	☐	Ulcers
☐	☐	Cancer: _____	☐	☐	Growths	☐	☐	Pacemaker	☐	☐	Allergies:_____
		_____	☐	☐	Hay Fever	☐	☐	Pregnancy			_____
☐	☐	Dizziness/Vertigo	☐	☐	Head Injuries	☐	☐	Radiation Treatment	☐	☐	Codeine Allergy
☐	☐	Diabetes	☐	☐	Heart Disease	☐	☐	Respiratory Problems	☐	☐	Penicillin Allergy
☐	☐	HbA1C:_____	☐	☐	Heart Murmur	☐	☐	Rheumatic Fever	☐	☐	MEDICATIONS LIST:
			☐	☐	Hepatitis						_____
											_____
											_____

- Do you premedicate prior to your appointment?_____
- Have you been admitted to a hospital or needed emergency care during the past two years?
  ☐ Yes ☐ No If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of physician:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

Dental History

	Yes	No	Details
Do you have any current dental problems?	☐	☐	_____
Date of last complete dental examination?	☐	☐	_____
Does food tend to become caught between your teeth?	☐	☐	_____
Are your teeth sensitive?	☐	☐	_____
Do you brush your teeth less than twice per day?	☐	☐	_____
Do you sip on energy drinks, juice or carbonated or non-carbonated soft drinks throughout the day?	☐	☐	_____
Have you ever had orthodontic treatment?	☐	☐	_____
Have you ever seen a periodontist?	☐	☐	_____
Do you have worn, broken or cracked teeth or fillings?	☐	☐	_____
Have you noticed any loose teeth or change in your bite?	☐	☐	_____
Have you noticed any mouth odors or bad tastes?	☐	☐	_____
Do your gums bleed or hurt?	☐	☐	_____
Do you feel nervous about having dental treatment?	☐	☐	_____
Have you ever had an upsetting dental experience?	☐	☐	_____
Are you happy with the appearance of your teeth?	☐	☐	_____
Would you like to keep your teeth all your life?	☐	☐	_____

TMJ Assessment

	Yes	No	
Do you have limited movement or locking jaw?	☐	☐	_____
Have you noticed any loose teeth or change in your bite?	☐	☐	_____
Do you clench or grind your teeth?	☐	☐	_____
Has your bite ever been adjusted?	☐	☐	_____
Do you get frequent headaches?	☐	☐	_____
Do you have difficulty opening or closing your mouth?	☐	☐	_____
Do you have jaw joint, neck, shoulder, face or back pain?	☐	☐	_____
Have you ever been told you have a TMJ problem?	☐	☐	_____
Do you have clicking or popping in your jaw?	☐	☐	_____

Oral Cancer Risk Assessment

	Yes	No	Details
Do you smoke tobacco?	☐	☐	_____
Do you chew tobacco or snuff?	☐	☐	_____
Do you have excessive sun exposure to your face?	☐	☐	_____
Do you drink more than two or three alcoholic drinks per day?	☐	☐	_____
Do you have sores (white or red) in your mouth or throat that do not heal?	☐	☐	_____
Is your voice hoarse or throat sore for a prolonged period of time?	☐	☐	_____
Do you have any lumps or thickening in your mouth or throat?	☐	☐	_____
Do you have difficulty chewing or swallowing?	☐	☐	_____
Do parts of your tongue or mouth feel numb?	☐	☐	_____
Do you have areas of swelling in your mouth?	☐	☐	_____
Do you wear dentures and have sore spots that won't go away?	☐	☐	_____
Does your tongue or other parts of your mouth deviate to one side when you try to move them?	☐	☐	_____

Health Risk Assessment

	Yes	No	Details
Do you snore?	☐	☐	_____
Have you been told that you gasp for air, snort, or stop breathing during sleep?	☐	☐	_____
Do you have difficulty concentrating or staying awake during the day?	☐	☐	_____
Do you wake up tired or quickly fall asleep while sitting, reading, watching TV or driving?	☐	☐	_____
Do you have a large or thick neck?	☐	☐	_____
Have you been tested for sleep apnea?	☐	☐	_____
When?	☐	☐	_____
Diagnosis?	☐	☐	_____
Do you wear a CPAP or dental device of sleep apnea?	☐	☐	_____

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.

_____	_____	_____
Print Name	Signature of Patient, Parent or Guardian	Date

Staff Notes

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