HAMPTON DENTAL GROUP PC

325 Meeting House Lane • Building 2 • Suite 401
Southampton • New York • 11968-7000

OFFICE POLICY
EMERGENCY AND/OR FIRST VISITS ARE TO BE PAID AT THE TIME OF TREATMENT

PATIENT MEDICAL-DENTAL HISTORY

(Dr.) / (Mr.) / (Mrs.) / (Miss) / (Ms.) Date: _____

Name _____ Birthdate: _____/_____/_____

Address (Mailing): _____ City, and Zip: _____

Address (Residence): _____ Email: _____

Home Phone: _____ Best Number to Reach You: _____ Cell Phone: _____

Next of Kin: _____ Phone: _____

Physician: _____ Previous Dentist: _____

Approximate date of last physical exam: _____ Last dental exam/cleaning/x-rays: _____

OCCUPATION: _____ Referred By: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS SO THAT WE MAY PROVIDE BETTER DENTAL CARE FOR YOU

1. Are you currently under medical treatment now? If yes, why? _____ **Y N**

2. Have you ever had any major operations? If yes, what? _____ **Y N**

3. Have you ever been hospitalized? If yes, why? _____ **Y N**

4. Do you have or have you ever had: **If you need help answering these questions, tell us.**

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches
☐	☐	Glaucoma

Y	N	Conditions
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV + AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems

Y	N	Conditions
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Veneral Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline
☐	☐	Other _____

_____

If female, please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant/nursing?
		If yes, # of weeks _____

5. **Have you ever received intravenous (IV) bisphosphonates such as Zometa (Zoledronate) or Pamidronate (Aredia)?** _____ **Y N**

If treated, please list the dates that bisphosphonates therapy was started and stopped: _____

_____

6. **Have you ever taken oral bisphosphonates such as Fosamax, Actonal or Boniva?** _____ **Y N**
If treated, please list the dates that oral bisphosphonates therapy was started and stopped: _____

_____

7. **Have you ever had oral surgery or periodontal surgery? Y N**

8. **Have you had any history or orthodontics, including an occlusal guard, night guard, retainer or implants? Y N**

9. **List any prescription medications that you are taking:** _____

_____

_____

_____

_____

_____

CONSENT FOR DENTAL TREATMENT

Permission is hereby granted to examine the listed patient, administer anesthetics and to employ such operative or technical procedures as may be deemed necessary or advisable in the diagnosis or treatment of the dental condition of the patient.

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

*** * * There will be a Broken Appointment Fee without 24 hours notice* * ***

_____ _____ _____

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

SOCIAL SECURITY NO.	**TYPE OF DENTAL INSURANCE (if applicable)**

WHO IS FINANCIALLY RESPONSIBLE FOR DENTAL BILL?

NAME _____ **PLACE OF EMPLOYMENT** _____

ADDRESS _____ **ADDRESS** _____

_____ _____

TELEPHONE _____ **TELEPHONE** _____

FINANCIAL DATA: (Must check one)

- **Cash or check at each appointment**
- **American Express, MasterCard, Visa or Discover at each appointment**
- **Credit arrangement with Financial Secretary**

I understand that Hampton Dental Group, P.C. is not a participating provider with any dental plan/insurance company/benefit fund, Medicaid, etc. and that I am financially responsible for my dental bill.*

*** As a courtesy to our patients, Hampton Dental Group, P.C. will attempt to maximize your dental plan's coverage as long as your plan allows the option for out-of-network providers.**

_____ _____

Date *Signature of Patient, Parent or Guardian*