Hudson
Family Dentistry

Date_____

Name_____ Sex ____M____F Age_____ Date of Birth_____
(Last) (First) (MI)

Address_____
(Mailing Address)

City_____State_____ Zip_____

Marital Status: Married_____ Widowed_____ Single_____ Minor_____ Separated_____ Divorced_____ Partnered____

Patient Employer/School: _____ Work Phone: _____

EMAIL ADDRESS: _____

Emergency Contact

Name _____ Relationship to Patient? _____
LAST FIRST MI

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Insurance

Who is responsible for this account: _____Relationship to Patient? _____

Home Phone_____ Cell Phone_____

Insurance Co. _____ Group#_____

Subscriber's Name: _____ Birth Date: _____

SSN: _____ Employer: _____

If the patient has additional insurance please notify someone at the front desk
****WHEN FILING INSURANCE THE SOCIAL SECURITY NUMBER & DATE OF BIRTH OF THE POLICY HOLDER ARE REQUIRED****

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Hudson Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I certify that all of this information is true and accurate including the following medical information.

Signature/Relationship: _____ Date: _____

PATIENT NAME: _____ **DOB:** _____

Dental History

Reason for today's visit: _____

Former Dentist_____City/State_____

Date of last dental visit: _____ Date of last dental x-rays: _____

Health History

Physician's Name _____ Date of Last Visit: _____

Name of Physician's Practice: _____Phone Number: _____

Are you on a Pain Contract?____Yes____No If so, with which Doctor? _____

Do you use tobacco products? ___Yes ___No

WOMEN ONLY:
Are you pregnant? ___Yes ___NO Due Date _____/_____/_____
MONTH DAY YEAR

Are you nursing? ___Yes ___No Are you taking Birth Control? ___Yes ___No

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Do you have a history of bacterial endocarditis? ____Yes ____No *If yes, when were you diagnosed? _____

Do you have history of any type of cancer? _____Yes _____No *If yes, what type of Cancer? _____

Are you currently taking chemotherapy or radiation treatments? _____Yes _____No

Have you ever taken any of the group of drugs collectively referred to as "**bisphosphanates**"? These include but are not limited to: Fosamax, Zometa, Aredia, Actonel, and Skelid. ____Yes ____No

Have you or are you currently taking any blood thinners? ____Yes ____No *If yes, what medication? _____

Do you have any stents, valves, or joint replacements? _____Yes ____No *If yes, when? _____

Do you have history of any heart attacks or strokes? ____Yes ____No *If yes, when? _____

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING:

_____ _____ _____

_____ _____ _____

_____ _____ _____

PLEASE LIST ANY KNOWN ALLERGIES:

_____ _____ _____

_____ _____ _____

PATIENT NAME: _____ **DOB:** _____

Pharmacy Name: _____ Phone: _____

Address _____City_____State_____ZIP_____

Place a mark (X) on "Yes" or "No" to indicate if you have or have had any of the following:

AIDS/HIV	___Yes ___No	Epilepsy	___Yes ___No	Rheumatic Fever	___Yes___No
Anemia	___Yes ___No	Fainting/Dizziness	___Yes ___No	Scarlet Fever	___Yes ___No
Arthritis, Rheumatism	___Yes ___No	Glaucoma	___Yes ___No	Short of Breath	___Yes ___No
Artificial Heart Valve	___Yes ___No	Headaches	___Yes ___No	Sinus trouble	___Yes ___No
Artificial Joints	___Yes ___No	Heart Murmur	___Yes ___No	Skin Rash	___Yes ___No
Asthma	___Yes ___No	Heart Problems	___Yes ___No	Special Diet	___Yes ___No
Bleeding abnormally, with		Hepatitis Type___	___Yes ___No	Stroke	___Yes ___No
Extractions or surgery	___Yes ___No	Herpes	___Yes ___No	Swollen Limbs	___Yes ___No
Blood Disease	___Yes ___No	High Blood Pressure	___Yes ___No	Swollen Glands	___Yes ___No
Cancer	___Yes ___No	Jaundice	___Yes ___No	Thyroid Problem	___Yes ___No
Chemical dependency	___Yes ___No	Kidney Disease	___Yes ___No	Tuberculosis	___Yes ___No
Chemotherapy	___Yes ___No	Liver Disease	___Yes ___No	Tumor or growth on head	
Circulatory Problems	___Yes ___No	Low Blood Pressure	___Yes ___No	or Neck	___Yes ___No
Congenital Hlth Lesions	___Yes ___No	Mitral Valve Prolapse	___Yes ___No	Ulcer	___Yes ___No
Cortisone Treatments	___Yes ___No	Nervous Problems	___Yes ___No	Weight Loss	___Yes ___No
Cough, persistent	___Yes ___No	Pacemaker	___Yes ___No	OTHER: _____	
Diabetes	___Yes ___No	Psychiatric Care	___Yes ___No	_____	
Emphysema	___Yes ___No	Radiation Treatment	___Yes ___No	_____	

Additional Notes:

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