Welcome

Hughes & Hughes Family Dentistry

1400 Horseshoe Pike, Glenmoore, PA 19343 • (610) 942-3321 • email:info@hughesdentistry.com

Today's Date: ____________________ **E-mail Address:** ____________________

Name: ____________________ (Last / First / Mi / Mr/Mrs/Ms/Dr) **I prefer to be called:** __________ ❑ Male ❑ Female

Birthdate: __/__/__ **Age:** ____ **Social Security #:** __________ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: ____________________ (Street / City / State / Zip)

Home #: (___) __________ **Cell #:** (___) __________ **Work #:** (___) __________ **Ext:** ____ **Driver License #:** __________

Where & when are best times to reach you? __________ **Whom may we Thank for referring you?** __________

Other family members seen by us: ____________________

Neighbor or Relative not living with you

His / Her Name: __________ **Relation:** __________ **Work #:** (___) __________ **Home #:** (___) __________

Address: ____________________ (Street / City / State / Zip)

Person Responsible for Account if other than yourself

Name: __________ **Relation:** __________ **Home #:** (___) __________ **Social Security #:** __________

Employer: __________ **Contact #:** (___) __________ **Ext:** ____ **Drivers License #:** __________

Billing Address: ____________________ (Street / City / State / Zip)

SPOUSE INFORMATION

His / Her Name: __________ **Birthdate:** __/__/__ **Social Security #:** __________

Employer: __________ **Contact #:** (___) __________ **Ext:** ____ **Drivers License #:** __________

INSURANCE INFORMATION

Primary Insurance **Dental Coverage?** ❑ Yes ❑ No **Orthodontic Coverage?** ❑ Yes ❑ No **Medical Coverage?** ❑ Yes ❑ No

Insurance Co. Name: __________ **Phone #:** (___) __________ **Group # (Plan, Local or Policy #):** __________

Insurance Co. Address: ____________________ (Street/PO Box / City / State / Zip)

Insured's Name: __________ **Insured's Social Security #:** __________ **Insured's Birthdate:** __/__/__ **Relation:** __________

Insured's Employer: __________ **Employer's Address:** ____________________ (Street/PO Box / City / State / Zip)

Secondary Insurance **Insurance Co. Name:** ____________________ ❑ Self ❑ Spouse

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be __________.

____
Signature Date

PAYMENT IS DUE AT TIME OF SERVICE

I certify that I am covered by __________ Insurance Co. and I assign directly to Dr. __________ all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

____
Signature Date

CONTINUED ON BACK

DENTAL HISTORY

Why have you come to the dentist today? ____________________

____

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental treatment (premed)? ❑ Yes ❑ No

Have you experienced problems associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

How long do you use a toothbrush before replacing it? ____________

Do you use anything in addition to your brush and floss? ❑ Yes ❑ No

If yes, what? ____________________

Would you like fresher breath? ❑ Yes ❑ No

Would you like whiter teeth? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Do you have mobility in your teeth? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? ____________

Do you still have wisdom teeth? ❑ Yes ❑ No

If yes, why? ____________________

Previous / Present Dentist: ____________ (Please Circle)

Last Visit Date: ____________

Why did you leave your previous dentist? ____________

What did you like most & least about any dentist you have seen?

____

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, what would you change? ____________

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: ____________________

Address: ____________________
Street City State Zip

Phone #: (___)____________ Date of last visit: ____________

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: ____________________

Have you ever taken Fosamax, or any other bisphosphonate? ❑ Yes ❑ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ❑ Yes ❑ No

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry / Metals	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other

Please list additional drugs/materials that cause allergic reactions:

____

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: ________ Are you nursing? ❑ Yes ❑ No

Are you taking any of the following?

Y N Acetaminophen	Y N Blood Thinners	Y N Insulin/Diabetes Drugs	Y N Thyroid Medicine
Y N Antibiotics	Y N Blood Pressure Medication	Y N Nitroglycerin	Y N Tranquilizers
Y N Antihistamines	Y N Cold Remedies	Y N Recreational Drugs	Have you ever taken Phen-Fen? Also known
Y N Aspirin	Y N Digitalis/Heart Medication	Y N Steroids/Cortisone	as Redux or Pondimin. ❑ Yes ❑ No

Are you taking any prescription/over-the-counter-drugs not listed above? ❑ Yes ❑ No If yes, please list each one: ____________

____

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Congenital Heart Defect	Y N Hepatitis	Y N Rheumatic Fever
Y N Alcohol Abuse	Y N Depression	Y N Herpes	Y N STD's
Y N Anemia	Y N Diabetes	Y N High Blood Pressure	Y N Scarlet Fever
Y N Anxiety	Y N Difficulty Breathing	Y N HIV+/AIDS	Y N Seizures
Y N Arrhythmia (i.e., A. Fib)	Y N Drug Abuse	Y N Hospitalized for Any Reason	Y N Shingles
Y N Arthritis	Y N Emphysema		Y N Sickle Cell Disease
Y N Artificial Bones/Joints	Y N Epilepsy	Y N Kidney Problems	Y N Sinus Problems
Y N Artificial Valves	Y N Fainting Spells	Y N Liver Disease	Y N Sleep Apnea
Y N Asthma	Y N Fever Blisters	Y N Low Blood Pressure	Y N Steroid Therapy
Y N Autoimmune Disease	Y N GERD	Y N Lupus	Y N Stroke
Y N Blood Transfusion	Y N Glaucoma	Y N Lyme Disease	Y N Thyroid Problems
Y N COPD	Y N Headaches	Y N Mitral Valve Prolapse	Y N Tonsillitis
Y N Cancer	Y N Heart Attack	Y N Pacemaker	Y N Tuberculosis (TB)
Y N Chemotherapy	Y N Heart Murmur	Y N Persistent Cough	Y N Ulcers
Y N Chicken Pox	Y N Heart Surgery	Y N Psychiatric Problems	
Y N Colitis	Y N Hemophilia	Y N Radiation Treatment	

Please list any serious medical condition(s) that you have experienced: ____________________

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