# Julia A. Hallisy, D.D.S., Inc.

Welcome! Thank you for choosing our office for your dental health needs. Please let us know if you need assistance when completing these forms.

## PATIENT INFORMATION

Name ______________________________________________  ____________________
Last  Middle  First  Your preferred name

Email address__________________________________ Date of Birth________________

Please check: Married Single Domestic Partner Widowed

Driver's License #___________________ Social Security #____________________

Phone numbers Home ______________Work _______________Cell _________________

Physical address ___________________________________________________________
Street Apt # City State Zip

Mailing address ____________________________________________________________
(If different than above) Street Apt # City State Zip

Name of Spouse, Partner or Parent____________________________________________

Emergency Contact Person ___________________________________________________
Name Relationship Phone Number

**Who may we thank for referring you? _________________________________**

## PATIENT'S DENTAL INSURANCE

Name of Insured _____________________ Social Security #______________________

Date of Birth ________________________ Relationship to Patient __________________

Name of Ins. Company _________________ Group/Policy# _________________________

Employer Name _______________________ Occupation ___________________________

## SECONDARY DENTAL INSURANCE

Name of Insured _____________________ Social Security #______________________

Date of Birth ________________________ Relationship to Patient __________________

Name of Ins. Company _________________ Group/Policy# _________________________

Employer Name _______________________ Occupation ___________________________

# DENTAL HISTORY

Name of Previous Dentist ______________________________ Last Visit__________________________

Reason for Last Visit __________________________________ X-rays taken______________________

Present Dental Concern ___________________________________________________________________

How often do you brush your teeth?_______________________ Floss?___________________________

Type of toothbrush used: ☐Manual ☐Electric ☐Medium Bristle ☐Soft Bristle

Check all used: ☐Mouthwash ☐Rubber Tip ☐WaterPik ☐Proxabrush ☐Toothpicks ☐Other

How often are your teeth cleaned? ☐3 mos ☐4 mos ☐6 mos ☐1 year ☐Other

My Dental Health is: ☐Excellent ☐Good ☐Fair ☐Poor

**PLEASE CHECK YES OR NO FOR THE FOLLOWING:**

| | | | | | |
|---|---|---|---|---|---|
| Do you have sensitive or sore teeth | Yes ☐ | No ☐ | Do you have any popping, clicking, or pain in your jaw? | Yes ☐ | No ☐ |
| Do your gums bleed when you brush or floss? | Yes ☐ | No ☐ | Does your jaw ever lock? | Yes ☐ | No ☐ |
| Do you have an unpleasant taste or odor in your mouth? | Yes ☐ | No ☐ | Do you have trouble opening your mouth widely? | Yes ☐ | No ☐ |
| Do you have a dry mouth? | Yes ☐ | No ☐ | Do you clench or grind your teeth? | Yes ☐ | No ☐ |
| Does food or floss catch between your teeth? | Yes ☐ | No ☐ | Do you have earaches, neck pain or tension headaches? | Yes ☐ | No ☐ |
| Have you lost any teeth? Reason: | Yes ☐ | No ☐ | Do you currently wear any type of night guard or splint for TMJ? | Yes ☐ | No ☐ |
| Have you ever had an injury to your mouth, head, or teeth? | Yes ☐ | No ☐ | Have you ever had orthodontic treatment or braces? | Yes ☐ | No ☐ |
| Have you ever had a dental infection or abscess? | Yes ☐ | No ☐ | Is your home water supply fluoridated? | Yes ☐ | No ☐ |
| Do you have any lumps or swelling in your mouth? | Yes ☐ | No ☐ | Do you drink bottled water? | Yes ☐ | No ☐ |
| Do you have any pain or difficulty swallowing? | Yes ☐ | No ☐ | Are you anxious about dental visits? | Yes ☐ | No ☐ |
| Do you ever have mouth sores (canker sores, cold sores)? | Yes ☐ | No ☐ | Have you had any problems with the effectiveness of dental anesthetics? | Yes ☐ | No ☐ |
| Have you ever had treatment for gum | Yes ☐ | No ☐ | Are you happy with the appearance of your teeth and smile? | Yes ☐ | No ☐ |
| Do you have any jaw problems or TMJ? | Yes ☐ | No ☐ | | | |

**Do you wear dentures or partials? If so, please complete the following:**

When was the appliance made?_____________________________________________

Name of Dentist providing the appliance ___________________________________

| | | |
|---|---|---|
| Has your appliance ever been relined? | Yes ☐ | No ☐ |
| Has your appliance ever been repaired? | Yes ☐ | No ☐ |
| Does your denture or partial fit well? | Yes ☐ | No ☐ |
| Do you need adhesive to keep your appliance in place? | Yes ☐ | No ☐ |

# MEDICAL HISTORY

Name of Physician: ________________________________ Phone (______) ________________________

Address/City/State__________________________________________________________________________

Date of last physical exam?________________________

**PLEASE CHECK YES OR NO FOR ALL OF THE FOLLOWING:**

| | | | | | |
|---|---|---|---|---|---|
| Abnormal Bleeding | Yes ☐ | No ☐ | Heart Murmur | Yes ☐ | No ☐ |
| Allergies/Hay Fever | Yes ☐ | No ☐ | Heart Pacemaker | Yes ☐ | No ☐ |
| Anemia | Yes ☐ | No ☐ | Heart Surgery | Yes ☐ | No ☐ |
| Angina | Yes ☐ | No ☐ | Hemophilia | Yes ☐ | No ☐ |
| Arthritis | Yes ☐ | No ☐ | Hepatitis: Type A☐ Type B☐ Type C☐ | Yes ☐ | No ☐ |
| Artificial Joint | Yes ☐ | No ☐ | High Blood Pressure | Yes ☐ | No ☐ |
| Artificial (prosthetic) Heart | Yes ☐ | No ☐ | HIV/AIDS | Yes ☐ | No ☐ |
| Asthma | Yes ☐ | No ☐ | Jaundice | Yes ☐ | No ☐ |
| Autoimmune Disease | Yes ☐ | No ☐ | Joint Replacement | Yes ☐ | No ☐ |
| Bisphosphonate Use (Actonel, Fosamax, Boniva, etc.) | Yes ☐ | No ☐ | Kidney Problems | Yes ☐ | No ☐ |
| Blood Transfusion | Yes ☐ | No ☐ | Liver Disease | Yes ☐ | No ☐ |
| Breathing Problems | Yes ☐ | No ☐ | Low Blood Pressure | Yes ☐ | No ☐ |
| Bronchitis | Yes ☐ | No ☐ | Lupus | Yes ☐ | No ☐ |
| Cancer | Yes ☐ | No ☐ | Mental Health Disorders | Yes ☐ | No ☐ |
| Chemical Dependency | Yes ☐ | No ☐ | Migraine Headaches | Yes ☐ | No ☐ |
| Chemotherapy | Yes ☐ | No ☐ | Mitral Valve Prolapse | Yes ☐ | No ☐ |
| Chronic Pain | Yes ☐ | No ☐ | Neurological Disorder | Yes ☐ | No ☐ |
| Congenital Heart Defect | Yes ☐ | No ☐ | Osteoporosis | Yes ☐ | No ☐ |
| Congestive Heart Failure | Yes ☐ | No ☐ | Radiation Treatment | Yes ☐ | No ☐ |
| Cough for longer than 3 weeks | Yes ☐ | No ☐ | Respiratory Problems | Yes ☐ | No ☐ |
| Cough that produces blood | Yes ☐ | No ☐ | Rheumatic Fever | Yes ☐ | No ☐ |
| Diabetes: Type I☐ Type II☐ | Yes ☐ | No ☐ | Rheumatic Heart Disease | Yes ☐ | No ☐ |
| Eating Disorder | Yes ☐ | No ☐ | Sexually Transmitted Disease | Yes ☐ | No ☐ |
| Emphysema | Yes ☐ | No ☐ | Sickle Cell Disease | Yes ☐ | No ☐ |
| Epilepsy or Seizures | Yes ☐ | No ☐ | Sinus Problems | Yes ☐ | No ☐ |
| Excessive Thirst | Yes ☐ | No ☐ | Sleep Apnea | Yes ☐ | No ☐ |
| Excessive Urination | Yes ☐ | No ☐ | Sleep Disorder | Yes ☐ | No ☐ |
| Fainting or Dizziness | Yes ☐ | No ☐ | Stroke | Yes ☐ | No ☐ |
| Frequent Cough | Yes ☐ | No ☐ | Surgical Shunt | Yes ☐ | No ☐ |
| Glaucoma | Yes ☐ | No ☐ | Swollen Glands | Yes ☐ | No ☐ |
| Heartburn or Reflux | Yes ☐ | No ☐ | Thyroid Problems | Yes ☐ | No ☐ |
| Heart Attack | Yes ☐ | No ☐ | Tuberculosis | Yes ☐ | No ☐ |
| Heart Disease | Yes ☐ | No ☐ | Ulcers | Yes ☐ | No ☐ |
| Heart Infection (Endocarditis or Pericarditis) | Yes ☐ | No ☐ | | | |

**MEDICAL HISTORY** (continued)

Do you have any health problems not listed above? Yes ☐ No ☐
If yes, please explain______________________________________________
______________________________________________

Have you been in the hospital or had a serious illness in the last 5 years? Yes ☐ No ☐
If yes, please explain______________________________________________
______________________________________________

Are you taking any prescription medications? Yes ☐ No ☐
If so, please list______________________________________________
______________________________________________
______________________________________________

Are you using over-the-counter meds, herbal meds, or other supplements? Yes ☐ No ☐
If so, please list______________________________________________
______________________________________________

Are you allergic to any medications or substances? Please check boxes below:

☐ Aspirin ☐ Penicillin ☐ Sulfa Drugs ☐ Tetracycline ☐ Other Antibiotics
☐ Local Anesthetics ☐ Codeine or other Narcotics ☐ Sleeping Pills ☐ Iodine
☐ Metal ☐ Latex ☐ Other, please list______________________________

Have you ever used tobacco? Yes ☐ No ☐
If yes, how long, type and amount______________________________

Do you drink alcoholic beverages? Yes ☐ No ☐
How often and how much? ______________________________

Women (please check) ☐ Pregnant ☐ Trying to get pregnant ☐ Nursing
☐ Using Oral Contraceptives ☐ Hormone Replacement Therapy

To the best of my knowledge, all of the above answers are correct. If I have any changes in my health status, I will inform the dentist and the staff before my next appointment.

______________________________________________ ______________________
Signature of Patient/Parent/Legal Guardian Date

______________________________________________ ______________________
Signature of Dentist Date

## APPOINTMENT CANCELLATION POLICY

We value your time and we do not "double-book" appointments. When you schedule an appointment with us, this time is reserved exclusively for you. Any change in this appointment affects many people, so we require notice of **two business days** if you are unable to keep your appointment. *Please Note: We reserve the right to charge a fee for appointments not cancelled two business days in advance. Signing this form indicates that you understand and will comply with our cancellation policy.

## FINANCIAL POLICY

Payment for your dental treatment is due at the time of service, unless financial arrangements are made prior to treatment. This policy is instrumental in helping us keep dental care costs down for our patients by reducing the significant expenses associated with billing procedures. There is a $25.00 fee for each returned check and balances over 60 days are subject to interest at the rate of 1.5% per month at our discretion.

## DENTAL INSURANCE POLICY

We are happy to submit your insurance claim, but please remember that your insurance policy is a contract between you and your insurance company. We do our best to estimate your co-payments and to help you utilize your insurance benefits. The patient is ultimately responsible for any amount not paid by insurance. We reserve the right to modify this policy at any time without further notice. Signing this form indicates that you understand and will comply with our financial policy.

## AUTHORIZATION AND CONSENT

I agree and consent to dental examination by this office. I understand that diagnostic procedures and dental treatments may be recommended and will be discussed in advance. To the best of my knowledge, I have completed this paperwork accurately and I will bring all future changes in my medical or dental history to the attention of the doctor. I understand that providing incorrect or incomplete information can be dangerous to my health. I grant permission for the office to contact me at home or work via telephone, email, or text messages. I will not hold my dentist, or any other member of her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

I authorize the release of information needed to process my insurance claims. I authorize my insurance benefits to be paid directly to this dental office.

I have received a copy of and understand the Notice of Privacy Practices and I have had a copy of the Dental Materials Fact Sheet made available to me.

________________________________________ ____________________

Signature of Patient/Parent/Legal Guardian Date