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 circle: 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 (please circle): Manual Electric Medium Bristle Soft Bristle

Circle 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:

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

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:

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

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