Welcome

Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's Date:_____

E-mail Address:_____

Name:_____

I prefer to be called:_____ Male Female

Birthdate:___/___/___ Age:___ SS#_____

Home Address:_____

_____

Single Married Partnered Divorced/Separated

Hm #: (___)_____ Cell #:_____

Wk #: (___)_____ Ext: _____

Employer: _____

Employer's Address: _____

INSURANCE

Primary Insurance

Insurance Co. Name:_____

Insurance Co. Address:_____

_____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____Relation:_____

Insured's Birthdate: ___/___/___ Insured's ID #:_____

Insured's Employer: _____

Employer's Address:_____

Do you have Secondary Insurance? YES NO

On the day of your appointment, please bring in *a physical copy* of your current, up-to-date insurance card so that our staff may scan it into your file. Alternatively, before your appointment you can send a picture of the *front AND back* of your card to our office number or email:

Phone: (319) 351-9723

Email: hagartyfamilydental@yahoo.com

Thank you!

Payment is due in full at the time of treatment
Unless prior arrangements have been approved.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-pay and deductibles that my insurance does not cover. I hereby authorize payment directly to Hagarty Family Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

Signature Date

Continue…….

MEDICAL HISTORY

Do you have a personal physician? ☐ YES ☐ NO

Physician's Name: _____

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: _____

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

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription/over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

Have you ever taken Fosamax, or any other bisphosphinate? ☐ Yes ☐ No

Have you ever taken Phen-fen? ☐ Yes ☐ No

<u>For Women</u>: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems (Please circle)

Abnormal bleeding/Hemophilia
AIDS
Alcohol/Drug Abuse
Anemia
Arthritis
Artificial Bones/ Joints/ Valves
Asthma
Blood Transfusion
Cancer/ Chemotherapy
Colitis
Congenital Heart Defect
Diabetes
Difficulty Breathing
Emphysema
Epilepsy
Fainting Spells
Frequent Headaches
Glaucoma
Hay Fever
Heart Attack/ Surgery
Heart Murmur
Hepatitis
Herpes/ Fever Blisters
High Blood Pressure
HIV
Hospitalized for Any Reason
Kidney Problems
Liver Disease
Low Blood Pressure
Lupus
Mitral Valve Prolapse
Pacemaker
Psychiatric Problems
Radiation Treatment
Rheumatic/Scarlet Fever
Seizures
Shingles
Sickle Cell Disease/Traits
Sinus Problems
Stroke
Thyroid Problems
Tuberculosis (TB)
Ulcers
Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____
_____

Are you allergic to any of the following? (Please circle)

Aspirin Erythromycin Penicillin

Codeine Jewelry/Metals Tetracycline

Dental Anesthetics Latex Other

Please list any other drugs/materials that you are allergic to:

_____
_____

Why have you come to the dentist today? _____
_____

Are you currently in pain? ☐ Yes ☐ No
Do you require antibiotics before dental treatment? ☐ Yes ☐ No

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

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you floss daily: ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Ever itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

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

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

Do you have any loose teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No

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

If not, what would you like to change?

_____
_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information 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 any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____
Signature Date