

WELCOME

Hyndman Area Health Center

PATIENT INFORMATION

Today's Date: _____

Patient Name: _____

Patient's Date of Birth: _____

Patient's Address: _____

Patient's Social Security #: _____

Patient's Phone #: _____

Cell Phone #: _____

Patient's Age: _____ Sex: _____

Marital Status: _____

RESPONSIBLE PARTY

Responsible Party: _____

Date of Birth: _____

Address: _____

Social Security #: _____

Phone#: _____

Cell Phone #: _____

Relationship to Patient: _____

Work Phone #: _____

INSURANCE INFORMATION

Name of Insured: _____

Relationship to Patient: _____

Address: _____

Date of Birth: _____

Social Security #: _____

Employer: _____

Phone: _____

Address: _____

Union or Local #: _____

Group #: _____

Insurance Company: _____

Phone #: _____

Address: _____

Member #: _____

Family/Single Coverage: _____

ADDITIONAL INSURANCE

Name of Insured: _____

Relationship to Patient: _____

Employer: _____

Social Security #: _____

Insurance Company: _____

Date of Birth: _____

Address: _____

Phone: _____

Group #: _____

PATIENT MEDICAL HISTORY

Primary Care Physician: _____ Phone #: _____ Date of Last Exam: _____

Have you ever been told you have one of the following? Check only if answer is yes.

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Bleeds Easily | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Fainting/Seizures | <input type="checkbox"/> Swollen Ankles |
| <input type="checkbox"/> Chest Pain –Angina | <input type="checkbox"/> Epilepsy/ Convulsions | <input type="checkbox"/> Hay Fever/Allergies |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Joint Replacement/Implant | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> AIDS/HIV | _____ |
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Kidney Disease | _____ |

Yes NO

1. Are you under medical treatment now? Why: _____
2. Have you ever had any other serious illness not listed above? What: _____
3. Are you currently taking any medications? What: _____
4. Have you ever had a bad reaction to local anesthetic or penicillin? What: _____
5. Do you use tobacco? _____
6. Do you use Alcohol, Cocaine or other drugs? What: _____
7. Women Only: Are you pregnant or think you may be pregnant? What month: _____
Are you taking birth control pills? _____
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PATIENT DENTAL HISTORY

- What is your reason for seeking care at this time: _____
- Do you have regular dental checkups? When was your last dental exam: _____
- Do you have any pain or discomfort now? What: _____
- Do your gums bleed? _____ Have you had surgery performed on your gums? _____
- Have you ever had a root canal? _____ Have you ever worn braces? _____ Do you wear Dentures? _____
- Do you grind your teeth? _____ Have you ever had any trauma to your face or mouth? _____
- Do you floss? How often _____ How many times a day do you brush your teeth? _____
-

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I also understand that I am responsible for any account balance and payment in full is expected at time of service, unless prior arrangements have been made. As a courtesy to our patients, your insurance claims will be completed for you. However, Insurance is between you and your insurance company. You are still responsible for any unpaid or denied claims.

All information is HIPPA compliant and will only be disclosed for medical or dental treatment.

Date: _____

Signature of Patient/Parent or Guardian _____