HALE & HALE
DDS, INC.

Confidential Patient Information
Susan E. Hale, DDS & Brent E. Hale, DDS

Date: _____

PERSONAL INFORMATION

Name: _____ Preferred Name: _____
Last First Middle Initial

Address _____
(Mailing) Street City State Zip

Address Residence: _____
(If different from mailing) Street City State Zip

If Patient Child, Parent's or Legal Guardian's Name: _____

Home Phone: _____ Birthdate: _____

Cell Phone: _____ Social Security #: _____

Work Phone: _____ Marital Status: [ ] Single
[ ] Married

E-mail: _____

Preferred Method of Contact: _____ Name of Spouse: _____
(Circle any that apply) Phone Cell Home Work Email Text Phone: _____

Emergency contact: _____

Whom may we thank for referring you to the office: _____

RESPONSIBLE FINANCIAL PARTY (If different from above)

Name: _____ Relationship to Patient: _____

Social Security #: _____ Date of Birth: _____

Phone (best place to contact): _____ E-mail: _____

Address: _____
Street City State Zip

PRIMARY DENTAL INSURANCE COMPANY

Insurance Company: _____ Subscriber Birthdate: _____

Phone#: _____ Subscriber SS# / ID #: _____

Subscriber Name: _____ Group #: _____
Last First Middle

Relation to Patient _____

Employer: _____

SECONDARY DENTAL INSURANCE COMPANY

Insurance Company: _____ Subscriber Birthdate: _____

Phone#: _____ Subscriber SS# / ID #: _____

Subscriber Name: _____ Group #: _____
Last First Middle

Relation to Patient _____

Employer: _____

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MEDICAL HISTORY

We understand that you are here or dental care. Medications you may be taking and your medical history may have an effect on your dental health. It could also make a difference in the best course of dental treatment for your personal situation. Thank you for taking the time to complete this form so that we can provide you with optimal care.

Physician's Name:_____ Phone Number: _____ Date of Last Physical: _____

Are you taking any medications, including regular dose Aspirin? [ ] Yes [ ] No

Please list: _____ Attach a separate sheet if necessary

Do you have ANY ALLERGIES (or adverse reaction to any medications)? [ ] Yes [ ] No

Please list: _____

Have you been hospitalized or under the care of a physician in the last 2 years? [ ] Yes [ ] No

Please list: _____

PLEASE CIRCLE YES OR NO ON ANY OF THE FOLLOWING THAT APPLY:

HEART PROBLEMS	[ ] Yes [ ] No	**ASTHMA**	[ ] Yes [ ] No	**ABNORMAL BLEEDING OR DISORDER**	[ ] Yes [ ] No
RHEUMATIC FEVER	[ ] Yes [ ] No	**EMPHYSEMA**	[ ] Yes [ ] No	**COUMADIN OR BLOOD THINNERS**	[ ] Yes [ ] No
HIGH BLOOD PRESSURE	[ ] Yes [ ] No	**TUBERCULOSIS**	[ ] Yes [ ] No	**ULCERS**	[ ] Yes [ ] No
LOW BLOOD PRESSURE	[ ] Yes [ ] No	**COPD**	[ ] Yes [ ] No	**CROHNS DISEASE**	[ ] Yes [ ] No
STROKE	[ ] Yes [ ] No	**SNORING**	[ ] Yes [ ] No	**LUPUS**	[ ] Yes [ ] No
HEART ATTACK	[ ] Yes [ ] No	**APNEA**	[ ] Yes [ ] No	**CANCER TYPE:** _____	[ ] Yes [ ] No
PACEMAKER	[ ] Yes [ ] No	**CPAP/SNORE GUARD**	[ ] Yes [ ] No	**ARTIFICIAL JOINTS OR PROSTHESIS**	[ ] Yes [ ] No
ENDOCARDITIS	[ ] Yes [ ] No	**MOUTH BREATHER**	[ ] Yes [ ] No	**AIDS OR HIV POSITIVE**	[ ] Yes [ ] No
MITRAL VALVE PROLAPSE	[ ] Yes [ ] No	**GASTRIC REFLUX**	[ ] Yes [ ] No	**SEXUALLY TRANSMITTED DISEASE**	[ ] Yes [ ] No
SMOKER OR CHEW TOBACCO	[ ] Yes [ ] No	**LIVER DISEASE/JAUNDICE**	[ ] Yes [ ] No	**DIABETES TYPE I OR TYPE II**	[ ] Yes [ ] No
LATEX ALLERGY OR SENSITIVITY	[ ] Yes [ ] No	**HEPATITIS A, B OR C**	[ ] Yes [ ] No	**FOR WOMEN:**	
EPILEPSY	[ ] Yes [ ] No	**HPV**	[ ] Yes [ ] No	**PREGNANT**	[ ] Yes [ ] No
SEIZURES	[ ] Yes [ ] No	**PSYCHOLOGICAL ISSUES**	[ ] Yes [ ] No	**NURSING**	[ ] Yes [ ] No
FAINTING	[ ] Yes [ ] No	**NEUROLOGIC DISORDER**	[ ] Yes [ ] No	**OTHER**	[ ] Yes [ ] No

If you circled any of the above, describe:

_____

DENTAL HISTORY

1) What prompted you to contact out office for an appointment (Chief Concern) _____

_____

2) Date of last dental exam _____ Prophylaxis(Cleaning) _____

Radiographs last three years? _____

3) Have you ever had any serious trouble associated with previous dentistry? ☐ Yes ☐ No

4) Are you happy with the appearance of your teeth? ☐ Yes ☐ No
If you answered 'No' and we could wave a magic wand over your head and instantly change anything about the appearance of your teeth, what would you change? _____

_____

5) What are some questions about dentistry and your oral health that you have never had adequately answered? _____

_____

_____

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Patient Name: _____ Date: _____
Last First Middle

NOTES

PERIODONTAL DISEASE AND DENTAL INFECTIONS MAY INCREASE THE RISK OF HEART DISEASE AND STROKE.
Recent studies have shown a link between diabetes and periodontal disease. It is important that both diseases are under control.
Pregnant women with periodontal disease may have up 7 times increased risk for a preterm, low birth weight baby.

ACKNOWLEDGMENTS

- I, _____ (Initials), acknowledge that I have received from Susan E. Hale, DDS/Brent E. Hale, DDS, a copy of the Dental Materials Fact Sheet dated May 2005.
- I grant authority to Drs. Brent & Susan Hale, Inc. to perform dental and surgical procedures and treatments, Including but not only the administrations of medicines and local anesthetics that are deemed necessary and/or advisable in the diagnosis and treatment of this patient.
- Patient and/or legal guardian/parent will be informed before treatments performed.
- I authorize the practice of Drs. Brent & Susan Hale, Inc. to release any information to expedite insurance claims.
- I consent to the taking and sharing of photographs/radiographs for laboratory, patient and doctor/specialist communication.
- I hereby certify the above to be true and correct to the best of my knowledge.
- This time has been reserved exclusively for you. A 24-hour notice is appreciated if you are unable to keep your appointment.
- **I understand that I am ultimately responsible for ANY and ALL charges regardless of insurance coverage.**

PAYMENT POLICY AND RELEASE OF RECORDS

I authorize this office to obtain or release medical information pertinent to patient care.

I authorize and request my insurance company to pay, directly to the doctor, insurance benefits otherwise payable to me.

I understand that insurance forms will be submitted on my behalf at no additional charge, however, I also acknowledge that the ultimate settlement of my account is my responsibility and not that of the insurance company.

I have had an opportunity to review the "Notice of Privacy Practices"

I certify that to the best of my knowledge, all of the above answers are true and correct. If I ever have a change in my medical history or medication, I will inform the dentist, hygienist, or office at my next dental appointment.

Patient/Authorized Signature: _____ Date: _____