PATIENT INFORMATION FOR WOODLANDS DENTAL PARTNERS

PART OF ALLAN HAMBURG, D.D.S., P.C.

We are pleased to welcome you and/or your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Date _____
SS/HIC/Patient ID# _____
Patient Name _____
Address _____
City _____
State _____ Zip
Email _____
Gender ☐ M ☐ F Age _____ Birthdate _____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____
Patient Employer/School _____
Employer/School Address _____
Employer/School Phone ( ) _____
Spouse's Name _____
Birthdate _____ SS# - -
Spouse's Employer _____
Whom may we thank for referring you? _____

DENTAL INSURANCE

Subscriber's Name _____
Relationship to Patient _____
Birthdate _____ SS# - -
Insurance Co. _____
Group # _____ Phone ( ) _____

Is patient covered by secondary insurance? ☐ Yes ☐ No
Subscriber's Name _____
Relationship to Patient _____
Birthdate _____ SS# - -
Insurance Co. _____
Group # _____ Phone ( ) _____

PHONE NUMBERS

Home ( ) _____ Work ( ) _____ Ext. _____ Cell ( ) _____
Spouse's Work _____ Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household) _____
Name _____ Relationship _____
Home ( ) _____ Work ( ) _____ Ext. _____ Cell ( ) _____

Reason for today's visit _____

Former Dentist _____
City/State _____
Date of last dental visit _____
Date of last dental X-rays _____
How often do you floss? _____
How often do you brush? _____
Do you wear contact lenses? ☐ Yes ☐ No

Is there anything else you would like us to know about you? _____

DENTAL HISTORY

Please check ☑ "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes ☐ No	Jaw pain or tiredness	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No	Lip or cheek biting	☐ Yes ☐ No
Blisters on lips or mouth	☐ Yes ☐ No	Loose teeth or broken fillings	☐ Yes ☐ No
Burning sensation on tongue	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No
Chew on one side of mouth	☐ Yes ☐ No	Mouth pain	☐ Yes ☐ No
Cigarette, pipe, or cigar smoking	☐ Yes ☐ No	Orthodontic treatment	☐ Yes ☐ No
Clicking or popping jaw	☐ Yes ☐ No	Pain around ear	☐ Yes ☐ No
Dry Mouth	☐ Yes ☐ No	Periodontal treatment	☐ Yes ☐ No
Fingernail biting	☐ Yes ☐ No	Sensitivity to cold	☐ Yes ☐ No
Food collection between the teeth	☐ Yes ☐ No	Sensitivity to heat	☐ Yes ☐ No
Foreign objects in mouth	☐ Yes ☐ No	Sensitivity to sweets	☐ Yes ☐ No
Grinding teeth	☐ Yes ☐ No	Sensitivity when biting	☐ Yes ☐ No
Gums swollen or tender	☐ Yes ☐ No	Sores or growths in mouth	☐ Yes ☐ No

MEDICAL HISTORY

Physicians Name _____ Date of last visit _____

Phone ( ) _____ Pharmacy _____ Phone ( ) _____

Please check ☑ "yes" or "no" to indicate if you have had any of the following:

AIDS	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	HIV Positive	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	**Have you ever had or been diagnosed with:**	
Chemical Dependency	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Artificial Heart Valves	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Artificial Joints, Screws, Pins	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Bleeding abnormally, with	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No	extractions or surgery	
Cough, persistent or bloody	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No	Blood Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No	Congenital Heart Lesions	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No	Hernia Repair	☐ Yes ☐ No
Fainting or dizziness	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Special Diet/Weight Loss	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No		
Hepatitis Type _____	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No	**Are you allergic to:**	
Herpes	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No	Aspirin	☐ Yes ☐ No
Have you ever had any complications following dental treatment?	☐ Yes ☐ No	**Have you ever taken any of these medications?**		Barbiturates	☐ Yes ☐ No
If yes, please describe: _____		Blood Thinners	☐ Yes ☐ No	Codeine	☐ Yes ☐ No
		• Coumadin	☐ Yes ☐ No	Ibuprofen	☐ Yes ☐ No
Have you ever been hospitalized or do you have		• Warfarin	☐ Yes ☐ No	Latex	☐ Yes ☐ No
Any other health concerns?	☐ Yes ☐ No	Diet Medications	☐ Yes ☐ No	Local Anesthesia	☐ Yes ☐ No
If yes, please describe:		• Dexfenfluramine	☐ Yes ☐ No	Metals (i.e. gold)	☐ Yes ☐ No
		• Fen-phen	☐ Yes ☐ No	Other	
		• Pondimin	☐ Yes ☐ No		
Women: Are you pregnant?	☐ Yes ☐ No	• Redux	☐ Yes ☐ No	**Please PRINT all medication you are now taking:**	
Due Date: _____		Levoxyl	☐ Yes ☐ No		
Are you nursing?	☐ Yes ☐ No	Synthroid	☐ Yes ☐ No		
Taking birth control pills?	☐ Yes ☐ No				

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Insurance Assignment: I certify that I, and/or my dependent(s), have insurance coverage with _____ And assign directly to
Name of Insurance Company(ies)

Dr. _____ All insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for All charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Authorization to Release Protected Health Information: I understand that there may be a need to consult with other health care providers. I voluntarily authorize

Dr. _____ to use and/or disclose my Protected Health Information (PHI) related to _____
Name of Doctor Disclosing PHI — Describe in detail the Protected Health Information

_____ The information will be used and/or disclosed for the purpose of _____
you are authorizing to be used and/or disclosed. — Describe each purpose for which you are authorizing

_____ I authorize Dr. _____ to receive and use the information.
your Protected Health Information to be used and/or disclosed. — Name of Doctor Receiving PHI

This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying, in writing, the above-named doctor disclosing the PHI. However, if I do revoke this authorization, it will not have any effect on any actions taken by the above-named doctor disclosing the PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please Print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

DOCTOR'S COMMENTS & UPDATES (to be completed by the dentist)

Medical Clearance Letter Sent to: _____ Date _____

Results: _____

Signature: _____ Date _____