Donald L. Hardee, DDS, PA

Family, Esthetic, and Implant Dentistry
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Phone 252-756-6626 ~ Fax 252-756-2147

1. ABOUT YOU

Today's Date: _____ Patient Name: _____
LAST FIRST MI
What you prefer to be called: _____ Male ☐ Female ☐ Birthdate: _____ Age: _____

SS#: _____ Mailing Address: _____
CITY STATE ZIP
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Referred By: _____

Employer: _____ How long? _____ Employer's Address: _____
CITY STATE ZIP
Occupation: _____ Status: Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Spouse's Name: _____ Do you have any children? Yes ☐ No ☐ How Many? _____

Are you a full time student? ☐ Yes ☐ No If yes, School Name: _____

2. INSURANCE INFORMATION

Primary Dental Insurance

Co. Name: _____
Address: _____
CITY STATE ZIP
Phone Number: _____
Insured's SS#: _____
Insured's ID#: _____
Group # (Plan, Local, Policy#): _____
Insured's Name: _____
Relation: _____ Date of Birth: _____
Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____
Address: _____
CITY STATE ZIP
Phone Number: _____
Insured's ID#: _____
Group# (Plan, Local, Policy#): _____
Insured's Name: _____
Relation: _____ Date of Birth: _____
Insured's Employer: _____

3. ACCOUNT INFORMATION

Person ultimately responsible for account

Name: _____ Relation: _____
Billing Address: _____
CITY STATE ZIP
SS#: _____ Work Phone: _____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.
INITIALS

4. IN EVENT OF EMERGENCY

Whom should we contact? _____ Relation: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Who is your Medical Doctor? _____ Medical Doctor's Phone: _____

(Continued on back)

(Continued from front)

5. DENTAL INFORMATION

Reason for today's visit: Exam ☐ Emergency ☐ Consultation ☐ Are you in pain? No ☐ Yes ☐ How long?_____

Please circle any of the following problems:

Discomfort, clicking or popping in jaw	Lost/Broken Filling(s)	Bad Breath
Blisters/Sores in or around mouth	Sensitive Teeth/Gums	Ringing in Ears
Teeth grinding/Locking jaw	Broken/Chipped Tooth	Red, swollen or bleeding gums

Other:_____

Do you require pre-medication?: Yes ☐ No ☐ Don't Know ☐

Previous Dentist:_____ Phone Number:_____ Last Dental Exam:_____ Last Dental X-rays:_____

Times a day you brush:_____ Times a week you floss:_____ What type of tooth brush bristles do you use? Soft ☐ Medium ☐ Hard ☐

Do your gums bleed when you floss and/or brush? Yes ☐ No ☐ Have you had your teeth bleached? Yes ☐ No ☐

Have you ever been told you had periodontal disease? Yes ☐ No ☐ Have you ever had braces? Yes ☐ No ☐ When?_____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

6. MEDICAL HISTORY

Please list ALL medications you are taking and why:_____

Are you allergic to any of the following? Latex ☐ Penicillin/Amoxicillin ☐ Aspirin ☐ Tetracycline ☐ Erythromycin ☐ Clindamycin ☐ Dental Anesthetics ☐

Foods:_____ Others:_____

Do you have or have you had any of the following diseases, medical conditions, procedures?

Y ☐ N ☐ Heart Attack/Stroke	Y ☐ N ☐ Thyroid Problems	Y ☐ N ☐ Cancer/Tumors	Y ☐ N ☐ Cosmetic Surgery
Y ☐ N ☐ Heart Surgery/Pacemaker	Y ☐ N ☐ Kidney Problems	Y ☐ N ☐ Shingles	Y ☐ N ☐ X-ray or Cobalt Treatment
Y ☐ N ☐ Heart Murmur	Y ☐ N ☐ Liver Problems	Y ☐ N ☐ Hepatitis	Y ☐ N ☐ Chemotherapy
Y ☐ N ☐ Rheumatic Fever	Y ☐ N ☐ Respiratory Problems	Y ☐ N ☐ HIV+/AIDS/ARC	Y ☐ N ☐ Arthritis/Rheumatism
Y ☐ N ☐ Nitral Valve Prolapse	Y ☐ N ☐ Sinus Problems	Y ☐ N ☐ Asthma	Y ☐ N ☐ Difficulty Breathing
Y ☐ N ☐ Artificial Bones/Joints	Y ☐ N ☐ Stomach Problems/Ulcers	Y ☐ N ☐ Artificial Valves	Y ☐ N ☐ Diabetes/Hypoglycemia
Y ☐ N ☐ Heart Disease	Y ☐ N ☐ Psychiatric Problems	Y ☐ N ☐ Emphysema	Y ☐ N ☐ Severe/Frequent Headaches
Y ☐ N ☐ Congenital Heart Defect	Y ☐ N ☐ Venereal Disease or STD	Y ☐ N ☐ Anemia	Y ☐ N ☐ Fainting/Seizures/Epilepsy
Y ☐ N ☐ Chest Pains	Y ☐ N ☐ Alcohol/Drug Abuse	Y ☐ N ☐ Leukemia	Y ☐ N ☐ High/Low Blood Pressure
Y ☐ N ☐ Scarlet Fever	Y ☐ N ☐ Tuberculosis TB	Y ☐ N ☐ Frequent Neck Pain	Y ☐ N ☐ Bleeding Problems
Y ☐ N ☐ Nervousness	Y ☐ N ☐ Jaw Problems TMJ/TMD	Y ☐ N ☐ Back Problems	Y ☐ N ☐ Glaucoma
Y ☐ N ☐ Pregnancy	Y ☐ N ☐ Osteoporosis	Y ☐ N ☐ Transplants	Y ☐ N ☐ Jaundice
Y ☐ N ☐ Lupus/MS/MD	Y ☐ N ☐ Fever Blisters	Y ☐ N ☐ Bulimia/Anorexia	

Please list any other surgeries or medical conditions you have or ever had:_____

_____

Do you use tobacco? Yes ☐ No ☐ Smoke ☐ Chew Tobacco/Snuff ☐ How much?_____ How long?_____

Please rate your general health from 1-10:_____ Do you wear contact lenses? Yes ☐ No ☐

FOR WOMEN: Are you taking Birth Control pills? Yes ☐ No ☐ How many children have you had?_____

Are you pregnant? Yes ☐ No ☐ How long?_____ Are you nursing? Yes ☐ No ☐

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

I authorize staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date_____

Adult Patient ☐ Parent/Guardian ☐ Spouse ☐