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

E-mail: _____ [ ] Married

Preferred Method of Contact: _____ Name of Spouse: _____

Emergency Contact: Name: _____ Phone: _____

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: _____
Name

SECONDARY DENTAL INSURANCE COMPANY

Insurance Company: _____ Subscriber Birthdate: _____

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

Subscriber Name: _____ Group #: _____
Last First Middle

Relation to Patient: _____

Employer: _____
Name

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MEDICAL HISTORY

We understand that you are here for 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 reactions 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 describe: _____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT APPLY:

HEART PROBLEMS	ASTHMA	ABNORMAL BLEEDING OR DISORDER	EPILEPSY
RHEUMATIC FEVER	EMPHYSEMA	COUMADIN OR BLOOD THINNERS	SEIZURES
HIGH BLOOD PRESSURE	TUBERCULOSIS	ULCERS	FAINTING
LOW BLOOD PRESSURE	COPD	CROHNS DISEASE	HPV
STROKE	SNORING	LUPUS	PSYCHOLOGICAL ISSUES
HEART ATTACK	APNEA	CANCER/TYPE: _____	NEUROLOGIC DISORDER
PACEMAKER	CPAP/SNORE GUARD	ARTIFICIAL JOINTS OR PROSTHESIS	FOR WOMEN:
ENDOCARDITIS	MOUTH BREATHER	AIDS OR HIV POSITIVE	PREGNANT
MITRAL VALVE PROLAPSE	GASTRIC REFLUX	SEXUALLY TRANSMITTED DISEASE	NURSING
SMOKER OR CHEW TOBACCO	LIVER DISEASE/JAUNDICE	DIABETES TYPE I OR TYPE II	OTHER
LATEX ALLERGY OR SENSITIVITY	HEPATITIS A, B OR C		

If you circled any of the above, describe: _____

_____

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 to 7 times increased risk for a preterm, low birth weight baby.

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: _____

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Patient Name: _____ Date: _____
Last First Middle

ACKNOWLEDGEMENTS

- I, _____, 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.

  (Initials)
- 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 treatment is performed.
- I authorize the practice of Drs. Brent & Susan Hale, Inc. to release any information to expediate 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.**

Authorized Signature: _____ Date: _____