DR. KATHRINE HAMMEL DMD
GENERAL DENTISTRY

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PATIENT INFORMATION

Name________________________________ Preferred name ___________________ Date: ______

Parent/Guardian (if Minor child) ____

Address ____________________________________City __________ State ____ Zip __________

Phones (home) ________________ (work) ____________________ (cell) ____________________

Date of birth _____________ (mm/dd/yr) Social Security #: ______________________

Email Address ____________________________ Occupation ______________________________

Student (Full or Part Time) School Name ____

IN CASE OF EMERGENCY CONTACT:

Name ______________________________ Phones (Home) _______________ (Cell) ______________

Relationship to Patient: Parent / Guardian / Spouse / Other __________________________________

INSURANCE INFORMATION:

Primary Insured Name: _______________________________________ Is insured a patient? Yes/ No

Last First MI

Insured's Birth Date: ________________ ID #: __________________ Group #: _____________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _______________

Insurance Plan Name and Address: ____

____

Secondary Insured Name: _____________________________________ Is insured a patient? Yes/ No

Last First MI

Insured's Birth Date: ________________ ID #: __________________ Group #: _____________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _______________

Insurance Plan Name and Address: ____

____

PATIENT MEDICAL HISTORY

Physician's name ________________________________ Phone ____________________

Are you now under the care of a physician? ? ☐ Yes or ☐ No If yes please explain:

____

Have you ever been hospitalized for any surgical procedure or serious illness? ☐ Yes or ☐ No

____

Are you taking any medication(s) including non-prescription and supplements? Please list?

____

____

Do you or have you had any of the following:

- ☐ High BP
- ☐ Liver Disease
- ☐ Low BP
- ☐ Hepatitis Type A / B / C
- ☐ Heart Attack
- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Pacemaker
- ☐ Hemophilia
- ☐ Bleeding problems
- ☐ Angina
- ☐ Diabetes Type I or II
- ☐ Cancer __________________
- ☐ Stroke
- ☐ Anemia
- ☐ Chest Pains
- ☐ Kidney Problems
- ☐ COPD
- ☐ Arthritis
- ☐ Emphysema
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Sinus Trouble
- ☐ Convulsions
- ☐ Fainting
- ☐ Epilepsy
- ☐ Asthma
- ☐ Blood Transfusion When? ______________
- ☐ HIV
- ☐ Joint Replacement When? ______________
- ☐ AIDS
- ☐ Edema
- ☐ Sexually transmitted disease
- ☐ Weight Loss
- ☐ Cold sores
- ☐ Mental illness
- ☐ Leukemia
- ☐

Did you receive Chemotherapy or Radiation? ______________

☐ Other Conditions:

____

____

Are you allergic to or have you had any reaction to the following:

- ☐ Penicillin
- ☐ Ibuprofen (Advil, Aleve)
- ☐ Local Anesthetics
- ☐ Prescription Pain Medications
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Tylenol
- ☐ Sedatives
- ☐ Topical Anesthetics
- ☐ Other ____

Do you use tobacco? ☐ Yes or ☐ No

Do you use alcohol? ☐ Yes or ☐ No How much and how often: ______________________

Do you use recreational drugs? ☐ Yes or ☐ No If yes, list: ______________________________

Do you have a history of Drug Addiction or Alcoholism? __________________________________

WOMEN ONLY:

Are you pregnant? ☐ Yes or ☐ No Are you nursing? ☐ Yes or ☐ No

Are you taking Birth control pills? ☐ Yes or ☐ No Are you post menopausal? ☐ Yes or ☐ No

DENTAL HISTORY

What is the reason for today's visit? ☐ Exam ☐ Consult ☐ Emergency

Do you have any specific dental concerns? Describe ______

When was your last dental appointment? ______

Typically in the past, did you have routine dental care? ☐ Yes or ☐ No

How often do you brush your teeth? ______ Do you floss? ______

Are there any sores in your mouth? ______

Do you want to keep your remaining teeth? ______

Are any of your teeth loose? ______

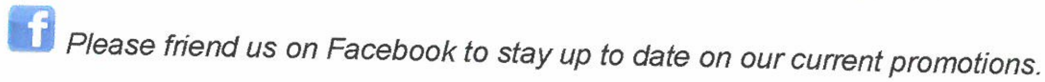
Are you happy with your smile? ______

Do any of your teeth currently hurt? ______

Whom may we thank for referring you? ______

How did you hear about us? ☐ Another patient ☐ A Friend ☐ Yellow Pages ☐ Insurance Carrier ☐ Internet ☐ Website ☐ Facebook ☐ Work ☐ Other ______

Preferred form of contact for confirming appts:
☐ Phone call (Listed above) ☐ Email (Listed Above) ☐ Text



To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______ Date: ______
Signature of patient, parent or guardian

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______ Date: ______ Relationship to Patient:
Signature of patient, parent or guardian

______ Date: ______ Relationship to Patient:
Signature of guarantor of payment/responsible party

______ Date: ______
Signature of Dentist