

Please return completed form
in person, or **submit via email**.
Thank you.

HALLMARK DENTAL

Work _____

Cell _____

Phone _____

(Please print)

Name: _____ SS# _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: M F Age: _____ Birthdate: _____

MARITAL STATUS:

Single Married Divorce Widowed Separated

Employer: _____ Occupation: _____

Business Address: _____ Work Phone: _____

Email Address: _____

Spouse Name: _____ Birthdate: _____

Employer: _____ Work Phone: _____

Business Address: _____ Occupation: _____

Who is responsible for payment? _____ Relation: _____

Do you have Dental Insurance? Yes No Name of Company: _____

Name of Insured: _____ SS# _____

Group # _____ INS Phone # _____

In case of emergency please notify:

Name: _____ Phone: _____

Whom may we thank for referring you? _____

Reason for your visit today? _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I also authorize payment directly to Hallmark Dental of the insurance benefits. I understand that I am responsible for all costs and that this authorization is irrevocable. (If a minor, legal guardian)

Date: _____ Signature: _____

(PLEASE FILL OUT MEDICAL HISTORY ON PG. 2)

Are you in pain? Yes No Date of last cleaning: _____

What did you dislike most about your last dentist or dental visit?

Do you smoke? Yes No Do your gums bleed? Yes No

Any discomfort in your jaw joint (TMJ/TMD)? Yes No

Do you like your smile? Yes No

Have you ever had any periodontal (gum) treatment? Yes No If yes, when? _____

Any reaction to anesthetic? Yes No

Have you ever had any of the following:

- | | | | |
|--|--|---------------------|--|
| Heart Attack/Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer/Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lung Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sinus Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial joints/bones | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy/Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | General allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drug/alcohol abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia/bleeder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| AIDS or other immunosuppressive disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Are you allergic to any medication? Yes No If so, what? _____

Are you taking any medication? Yes No If so, what? _____

Are you under the care of a physician? Yes No If so, for what? _____

(Women) Are you pregnant? Yes No Are you nursing? Yes No

Is there anything we should know about your dental or medical history?

Physician's Name: _____ Phone: _____