HUNSAKER DENTAL

1401 Gateway Boulevard, Ste. #3
Rock Springs, Wyoming 82901

Tel (307) 362-7671 - Fax (307) 362-3338
www.hunsakerdentistry.com

Thank you for choosing Hunsaker Dental for your dental care.
We want your visit to be pleasant and comfortable.

Date: _____

PATIENT INFORMATION

Name: _____ DOB: _____ SSN#: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email: _____ ❑ Male ❑ Female Cell Phone: _____

Are you: ❑ Minor ❑ Married ❑ Divorced ❑ Widowed ❑ Single

Spouse or Parent's Name: _____ Phone: _____

Person to contact in case of emergency: _____ Phone: _____

RESPONSIBLE PARTY

Name of person responsible: _____ Relationship: _____

Phone: _____ SSN#: _____

Address: _____

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Name of Insurer: _____ Relationship: _____

DOB: _____ SSN# _____ Name of employer: _____

Insurance Co.: _____ Group #: _____

Insurance Co. Address: _____ Subscriber ID#: _____

City: _____ State: _____ Zip: _____

I authorize and request my insurance company to pay directly to the Dentist insurance otherwise payable to me. I authorize the doctor to release all information necessary to secure payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance claims.

Signature: _____ Date: _____

MEDICAL HISTORY

Physician's Name: Date of last visit:

Please check if you have any of the following:

CONDITIONS:

- ❑ Angina Pectoris
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Blood /Bleeding Disorder
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cortisone Treatments
- ❑ Cold Sores
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Epilepsy
- ❑ Fainting/seizures
- ❑ HIV/AIDS
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Joint Replacement
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Ulcers

IF FEMALE:

- ❑ Are you taking Birth Control?
- ❑ Are you pregnant?
  If yes, # of weeks _____

ALLERGIES:

- ❑ Asprin
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Latex
- ❑ Metals
- ❑ Penicillin
- ❑ Sulfa
- ❑ Barbituites, sedatives or sleeping pills
- ❑ Other _____

Do you have any disease, condition, or problem not listed? _____

Medications you are currently taking: _____

Have you been hospitalized in the last 5 years? _____

DENTAL HISTORY

What is your chief reason for being here? _____

Whom may we thank for the referral? _____

When was your last dental visit? _____ What was done? _____

Have you had any serious trouble associated with any dental treatment? If so, explain... _____

_____

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

How often do you brush? _____ How often do you floss? _____ Do you use tobaco or smoke? ❑ Yes ❑ No

SELF /SMILE ANALYSIS

❑ Yes ❑ No Are your teeth sensitive?
❑ Yes ❑ No Do any of your teeth ache?
❑ Yes ❑ No Do your gums feel tender or swollen?
❑ Yes ❑ No Do you clench or grind your teeth?
❑ Yes ❑ No Are you tense during dental visits?
❑ Yes ❑ No Does your jaw ache?
❑ Yes ❑ No I am happy with my smile.
❑ Yes ❑ No I wish my teeth were whiter.
❑ Yes ❑ No I wish my teeth were straighter.

AUTHORIZATION

I certify that all of the above medical and dental information is true to my knowledge and that I have not omitted any pertinent information. I consent to the performing of dental or oral surgery procedures agreed to be necessary and advisable, including the use of local anesthetic and nitrous oxide as indicated. I understand that I will be informed of any treatment changes as they occur. I wish to assign any benefits under my dental insurance policy to Hunsaker Dental if applicable I will assume responsibility for all fees associated with any procedures and costs incurred from my dental treatment.

Patient's (Parent's) Signature: _____ Date: _____

MEDICAL UPDATE

Date	Condition	Dr. Int.
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____