Hulen DENTAL
STOVALL • CHENG • THORBURN

Date: _____

Name: _____ Preferred Name _____ M ☐ F ☐ Date of Birth _____

Address: _____ Zip Code: _____

If child; Parent name: _____ Date of Birth _____

Home Phone: _____ Cell Phone: _____ E-mail Address: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Spouse's Name: _____ Date of Birth _____ Cell Phone: _____

Spouse's Occupation: _____ Employer: _____ Employer Phone: _____

Who referred you to our office? _____

Person responsible for dental investment: _____

For Insurance Purposes:

Name of Insurance Carrier: _____ Name of Insured: _____

Social Security Number or ID _____ Group Number: _____

Are you covered by another plan? ___ If so, Name of Carrier: _____

Name of Insured _____ Social Security Number or ID _____ Group Number: _____

Are your teeth sensitive to:	Yes	No
Heat?	☐	☐
Cold?	☐	☐
Sweets?	☐	☐
Biting Pressure?	☐	☐
Does food catch between your teeth?	☐	☐
Do your gums bleed when brushing?	☐	☐
Have you noticed any gum swelling around any teeth?	☐	☐
Do you have an unpleasant taste or odor in your mouth?	☐	☐
Problems of the Jaw:		
Clicking of the jaw	☐	☐
Pain (joints, ear, side of face)	☐	☐
Difficulty opening or closing	☐	☐
Difficulty chewing	☐	☐
Do you ever avoid any part of the mouth while brushing?	☐	☐
Have you had a reaction to a local anesthetic?	☐	☐
Are you dissatisfied with your teeth & their appearance?	☐	☐
Are you deeply concerned about the finances required to return your teeth to excellent dental health?	☐	☐
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?	☐	☐
Do you have any fears?	☐	☐
Have you ever had any teeth removed?	☐	☐
How long have these teeth been missing? _____		
Do you feel you will eventually wear artificial dentures?	☐	☐
When was your last dental appointment? _____		
Why did you leave your last dentist? _____		

	Yes	No
Do you have any general health problems?	☐	☐
If so, please specify: _____		
Have you had surgery?	☐	☐
If so, please specify: _____		
Are you currently under a physician's care?	☐	☐
Reason: _____		
Any Medications? _____		
Do you smoke?	☐	☐
To the best of your knowledge, are you or have you ever been afflicted with:		
Heart Ailment _____	☐	☐
Diabetes	☐	☐
Rheumatic Fever	☐	☐
Epilepsy/Seizures	☐	☐
High Blood Pressure	☐	☐
Respiratory Disease/Asthma	☐	☐
Hepatitis A, B, or C	☐	☐
HIV Positive	☐	☐
Prolonged Bleeding	☐	☐
Healing Complications	☐	☐
Allergy to any Drug/Latex/Metal	☐	☐
Artificial Joints (hip, knee, etc)	☐	☐
Are you Pregnant?	☐	☐

What is your present dental problem?

_____

The above personal, dental, and medical history is complete and accurate, and I have not knowingly withheld information. I authorize the dentist to perform diagnostic procedures and administer treatment. I will be presented options and allowed to ask questions. I take full responsibility for payment for all procedures during treatment regardless of dental insurance.

Signature: _____

SUBMIT