Date_____

Richard Hall D.D.S., P.C.
260 Godwin Avenue
Wyckoff, NJ 07481

Thank you for choosing our practice for your dental needs. Please complete, print and sign the following forms. If you have any concerns, please ask for assistance. We are happy to help.

Patient Information

Name_____ **Social Security Number**_____
Home Address_____ **Date of Birth**_____
City_____ **State/Zip**_____
Home Phone_____ **Cell Phone**_____
Work Phone_____ **E Mail** _____

Are you? Single Married Divorced Widowed

Referred By?_____

Emergency Contact

Full Name_____ **Phone**_____
Relationship_____

Person Responsible for Payment Primary

Insurance Company_____
Employer Name_____ **Group No**_____
Full Name_____ **Social Security Number**_____
Home Address_____ **Date of Birth**_____
City_____ **State/Zip**_____

Person Responsible for Payment Secondary

Employer Name_____ **Group Number**_____
Full Name_____ **Social Security Number**_____
Home Address_____ **Date of Birth**_____
City_____ **State/Zip**_____

-MEDICAL HEALTH HISTORY

Former Dentist_____Approx date of last visit_____

Reason for this visit_____

How often do you brush?_____floss?_____

Please circle any that apply to you:

Bad breath	Gum surgery
Bleeding gums	Injury to face
Clicking jaw	Sensitivity when biting
Grinding/Clenching	Sensitivity to cold

Please list all **medications** you are currently taking

_____

_____

Have you ever been to **pre-medicate** prior to dental treatment?_____
Antibiotic given?_____

_____

Please list all known **Allergies**

_____

_____

Women: Are you pregnant?_____ Nursing:_____
Taking birth control pills?_____
Are you or have you ever taken medications for osteoporosis _____

Do you have a history of the following? (Please circle)

Aids/HIV	Allergies	Nervous Problems	Thyroid Problem
Heart Surgery	Sinus Problems	Anemia	Other_____
Mitro Valve Prolapse	Asthma	Hepatitis	Pace Maker
Heart Murmur	Respiratory disease	Ulcers	
Artificial Heart Valves	Rheumatic Fever	Arthritis	
Artificial Joints	Shortness of Breath	Psychiatric Care	
Glaucoma	Fainting Spells	Head Injury	
Hemophilia	Skin Rash	Cancer	
High Blood Pressure	Diabetes	Chemo/Radiation	
Chemical Dependency	Smoke/Chew Tobacco	Stroke	

Authorization

I certify that I have read and understood the information in the medical and dental history form.

The above questions have been accurately answered.

I authorize Dr. Hall to release any information including diagnosis and records of any treatment or examination rendered to me or my child to third party payers and or health practitioners for the purpose of providing therapy or processing insurance claims.

I authorize Dr. Hall to take any photographs of my teeth and dependants teeth and related oral tissue for diagnosis or educational purposes. I understand no image including the eyes or facial features will be taken that can reveal my identity.

I agree to be responsible for payment of all services rendered on my behalf along with any interest charges and collection fees.

I have been given the opportunity to read or have received a copy of Dr. Hall's Privacy Practices/HIPPA Compliance.

Please Note: We have a 24 hour cancellation policy. There will be a $65.00 charge for a missed appointment. NO EXCEPTIONS.

Signature _____ Date _____

For Professional Use Only:

Date:

Date:

Date: