Dr. David J. Hall, Jr.

802 Timber Dr. -- Garner, NC 27529

(919) 773-2266

*** We do not file Insurance, but will be glad to print an acceptable insurance receipt for you to file if you bring your insurance card.*

PATIENT INFORMATION (Confidential)

Date:					
Patient's Name:					
Birthdate:		**SS Number:**			
Address:					
City:		**State:**		**Zip Code:**	
Home Phone:		**Work Phone:**		**Cell Phone:**	
Gender:		**Marital Status:**			
Employer:					

Whom may we thank for referring you?

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name:		**Relationship:**			
Home Phone:		**Work Phone:**		**Cell Phone:**	

PERSON RESPONSIBLE FOR PAYING THIS ACCOUNT (If different from patient)

Name:		**Relationship:**			
Birthdate:		**SS Number:**			
Address:					
City:		**State:**		**Zip Code:**	
Home Phone:		**Work Phone:**		**Cell Phone:**	
Employer:					

For your convenience, we offer the following methods of payment. Please check the option you prefer.
Payment is due at the time of your appointment.

☐ Cash ☐ Personal Check ☐ Visa ☐ Mastercard

HEALTH HISTORY

1. Are you having pain or discomfort at this time? ☐ Yes ☐ No
2. Do you feel very nervous about having dental treatment? ☐ Yes ☐ No
3. Have you ever had a bad experience in the dental office? ☐ Yes ☐ No
4. Date of last dental visit ______
5. Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

   Physician's Name ______ Phone ______

6. List all medications and drugs and dosages you are currently taking:

______

7. Check any of the following medications to which you are allergic or have reacted adversely:

☐ Aspirin	☐ Nitrous Oxide	☐ Valium	☐ Penicillin	☐ Latex gloves
☐ Darvon	☐ Erythromicyn	☐ Scopolamine	☐ Other Antibiotics	Other ______
☐ Codeine	☐ Tetracycline	☐ Local Anesthetic	☐ Novocaine or Xylocaine	
☐ Demerol	☐ Percodan	☐ Nembutal/Seconal	☐ Sleeping pills	

8. Check any of the following which you have had or have at present:

☐ Heart Failure	☐ Cough	☐ Liver Disease
☐ Heart Disease or Attack	☐ Tuberculosis (TB)	☐ Yellow Jaundice
☐ Angina Pectoris	☐ Asthma / Hay Fever	☐ Blood Transfusion
☐ High Blood Pressure	☐ Sinus Trouble	☐ Drug Addiction
☐ Heart Murmur	☐ Allergies or Hives	☐ Hemophilia
☐ Rheumatic Fever	☐ Diabetes	☐ Venereal Disease (Syphilis, Gonorrhea)
☐ Congenital Heart Lesions	☐ Thyroid Disease	☐ Cold Sores / Fever Blisters
☐ Scarlet Fever	☐ Chemotherapy (Cancer, Leukemia)	☐ Epilepsy or Seizures
☐ Artificial Heart Valve	☐ Arthritis	☐ Fainting or Dizzy Spells
☐ Heart Pacemaker	☐ Rheumatism	☐ Psychiatric Treatment
☐ Heart Surgery	☐ Cortisone Medicine	☐ Sickle Cell Disease
☐ Anemia / Bruise Easily	☐ Glaucoma	☐ Hip Replacement
☐ Stroke	☐ Pain in Jaw Joints	☐ Knee Replacement
☐ Kidney Trouble	☐ A.I.D.S.	☐ Shoulder Replacement
☐ Ulcers	☐ Hepatitis A (infectious)	Other ______
☐ Emphysema	☐ Hepatitis B (serum)	

9. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ☐ Yes ☐ No

10. Do you have or have you ever had any of the following

MOUTH			TEETH		
Bleeding, sore gums	☐ Yes	☐ No	Loose teeth	☐ Yes	☐ No
Unpleasant taste/bad breath	☐ Yes	☐ No	Sensitive to hot	☐ Yes	☐ No
Burning tongue/lips	☐ Yes	☐ No	Sensitive to cold	☐ Yes	☐ No
Frequent Blister, lips/mouth	☐ Yes	☐ No	Sensitive to sweets	☐ Yes	☐ No
Swelling/lumps in mouth	☐ Yes	☐ No	Sensitive to biting	☐ Yes	☐ No
Ortho Treatments (braces)	☐ Yes	☐ No	Food impaction	☐ Yes	☐ No
Biting Cheeks/lips	☐ Yes	☐ No	Clenching/grinding	☐ Yes	☐ No
Clicking/popping jaw	☐ Yes	☐ No	Shifting in bite	☐ Yes	☐ No
Difficulty opening or closing jaw	☐ Yes	☐ No	Change in bite	☐ Yes	☐ No

11. Do you use the following:

Brush ☐ Yes ☐ No Fluoride rinse ☐ Yes ☐ No Dental floss ☐ Yes ☐ No Other ______

Authorization and Release

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. Payment for dental services are due on the day of your scheduled appointment. If you have dental insurance we will request the insurance company to pay you directly. I understand that my dental insurance carrier may pay less than the actual bill for services. Therefore, I agree to be responsible for payment of all services on my behalf or my dependents.

X ______

Signature of patient (or parent/guardian if minor)