James B. Hair, D.D.S.
Restorative & Cosmetic Dentistry

1441 Avocado Ave. Suite 308
Newport Beach, CA 92660
P: (949) 675 1146
F: (949) 675 3491

PATIENT INFORMATION

Please Print - Complete Entire Form

Patient Name_____ Birthdate_____/_____/_____Age_____

Address_____ ❑ Single ❑ Married ❑ Divorce ❑ Widowed

City_____State_____Zip_____ Cell Phone (_____) _____

Occupation_____ Home Phone (_____) _____

Employer_____ SSN: _____

Work Address_____ Work Phone (_____) _____

_____ Email:_____

Dental Ins. Co._____ Group # _____

Is Patient a College Student? ❑ Yes ❑ No Number of Units_____

Name of School_____ School Location (City)_____

How were you referred?_____

RESPONSIBLE PARTY IF NOT SELF / INSURED PERSON

Responsible Party if not Self_____ Birthdate_____/_____/_____

Address if different_____ Relation to Patient_____

City, State & Zip Code_____ Drivers License #_____

Occupation_____SSN: _____ Home Phone (_____) _____

Employer_____ Work Phone (_____) _____

Work Address_____

Insurance Company Name _____ Group # _____

DUAL COVERAGE

Is Patient covered by other Dental Plan? ❑ Yes ❑ No Ins. Co. _____ Group # _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to James B. Hair, D.D.S. I understand I am financially responsible for all monies not covered by this authorization. **Initial**_____

OFFICE POLICY

Appointment times are reserved exclusively for you. To avoid a broken appointment fee of $50, 24 hour notice is required.

Date_____Signature _____

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MEDICAL HISTORY

Patient's Name:_____

1. Are you in good health? Yes ❑ No ❑ If no, explain_____

_____

2. Have you been treated by a physician during the past 5 years? Yes ❑ No ❑ If yes, explain_____

_____

3. Have you had any serious illness, operation or hospitalization in the past 5 years? Yes ❑ No ❑ If yes, explain_____

_____

4. Please list any medication that you are sensitive or allergic to: (penicillin, etc.)_____

5. Please list any medication that you are currently taking:_____

6. For Females Only: Are you or could you be pregnant? Yes ❑ No ❑ Are you taking birth controll pills? Yes ❑ No ❑

7. Please check each box, yes or no, if the patient has ever had the illness or condition listed below please do not leave blanks:

Y	N		Y	N		Y	N	
❑	❑	AIDS or HIV Positive	❑	❑	Fainting or Dizziness	❑	❑	Nervous or Mental Health Issues
❑	❑	Allergies	❑	❑	Gastrointestinal Problems	❑	❑	Night Sweats
❑	❑	Angina or Heart Attack	❑	❑	Glaucoma	❑	❑	Radiation Therapy
❑	❑	Artificial Joint / Date:_____	❑	❑	Headaches or Migraines	❑	❑	Respiratory Problems
❑	❑	Asthma	❑	❑	Heart Bypass or Pacemaker	❑	❑	Rheumatic Fever
❑	❑	Bisphosphonate (Fosamax, etc.)	❑	❑	Heart Murmur	❑	❑	Seizure or Epilepsy
❑	❑	Bleeding Disorder	❑	❑	Hepatitis or Jaundice	❑	❑	Sexually Transmitted Diseases
❑	❑	Cancer	❑	❑	High Blood Pressure	❑	❑	Sinus Problems
❑	❑	Chemotherapy	❑	❑	Immunocompromised	❑	❑	Stroke
❑	❑	Cold Sores	❑	❑	Kidney Disease	❑	❑	Thyroid Problems
❑	❑	Diabetes	❑	❑	Latex Allergy	❑	❑	Tuberculosis
❑	❑	Dry Mouth	❑	❑	Mitral Valve Prolapse	❑	❑	Tumor or Growths

DENTAL HISTORY

1. Dental complaint at this moment:_____

2. When was your last dental visit?_____What treatment was done?_____

3. Have you had any serious trouble associated with any previous dental treatment? Yes ❑ No ❑ If yes, explain_____

_____

4. Does dental treatment make you nervous? No ❑ Slightly ❑ Moderately ❑ Extremely ❑

5. Have you ever had any of the following?

Y	N		Y	N	
❑	❑	Teeth sensitive to cold, heat, sweets, or pressure	❑	❑	Unpleasant taste in mouth or bad breath
❑	❑	Bleeding Gums. How long?_____	❑	❑	Periodontal (gum) surgery or extra procedures
❑	❑	Clenching or grinding	❑	❑	Orthodontic treatment
❑	❑	Swelling, sores, or lumps in the mouth	❑	❑	Pain around ears, in jaw muscles, or jaw joints

PERMISSION FOR CONSULTATION, TREATMENT AND/OR MEDICATIONS - I, the undersigned, being the patient, parent or guardian of the minor patient, consent to consultation and the performing of such dental operations or procedures as may be deemed necessary or advisable in the opinion of the Doctor and to the administration of medications deemed necessary including local anesthesia, antibiotics, analgesics (pain medications), sedatives and nitrous oxide. Initial_____

I have reviewed the information indicated in the questionnaire and it is accurate to the best of my knowledge. I will inform the dentist of any changes in my medical status. Initial_____

Patient/Parent/Guardian signature_____ Date _____

Reviewed by:_____ Date_____