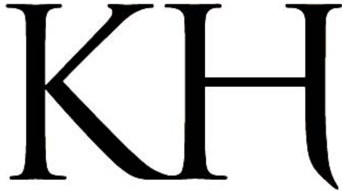

Kenneth M. Hamlett, DDS, FAGD,FAACD
8100 Lomo Alto, Suite 110
Dallas, Texas 75225
214.363.9474 phone 214.363.8749 fax
www.DrHamlett.com

Please Complete and Return to the Business Office

Personal Information

Name: Last First Middle

Address: Street or P.O. Box # City State Zip code

Phone Number:
Home:
Work:

Pager#: Cell Phone: Email Address:

Age: Yrs. Birth Date: Mo. Day Year

❒ Married
❒ Single
❒ Child

Social Security No: (if child, parents) Driver's License No:

Occupation: Employer: Address & Phone No.

Person responsible for bill: Age: Address: Relationship:

Social Security No:
Driver's License No:

Occupation: Employer: Address & Phone No:

Getting to Know You

1. Why did you select our practice? ______________
____
____
2. Whom may we thank for referring you?
____
3. Is another member of your family or relative a patient in our practice? ______________
____
4. Person to contact for emergency: ______________
Phone: ______________
5. When was your last dental visit? ______________
6. When was the last time you had complete dental radiographs taken? ______________
Name and Address of last Dentist:
____
____
7. Have you ever had any teeth removed? ______________
How long have these teeth been missing? ______________
Have these teeth been replaced? ______________
How? ❒Bridge ❒Partial ❒Denture ❒Implants

For All Patients

To the best of my knowledge, all of the preceding answers are true and correct. If I have a change in my health, or medicines, I agree to inform Dr. Hamlett at my next appointment. I authorize Dr. Hamlett and his assistants to examine, diagnose, and perform dental treatments on myself. I understand that I am responsible for all costs of dental treatment. I also give my consent for any of the photography, recording and x-ray procedures of my treatment to be used for teaching, research, educational, promotional purposes for the advancement of dentistry. I agree to pay for all services rendered by this office.

____

Signature of Responsible Party Relationship Date

MEDICAL HISTORY

1. How do you feel about getting and maintaining a healthy mouth?

____

2. How do you feel about the appearance of your teeth?

____

3. If you could change anything about your smile, what would you change?

____

4. Are you having dental problems at this time?……… ❒ Yes ❒ No
   a. Do your gums bleed at any time?……… ❒ Yes ❒ No
5. Do you feel very nervous about having dental treatment?……… ❒ Yes ❒ No
6. Have you ever had a bad experience in the dental office?……… ❒ Yes ❒ No
7. Please rank the following in the order of which they would keep you from having dental treatment:

______ Fear of Pain ______Cost of Treatment ______Lack of Concern ______Missing work time

8.Have you been under the care of a medical doctor during the past two years?……… ❒ Yes ❒ No
If yes: for what reason?

____

Please provide the name, address, and telephone number of your physician.

____

9. Have you been a patient in the hospital during the past two years?……… ❒ Yes ❒ No
   If yes: for what reason?

____

10. Have you taken any medicine or drugs during the past two years? If yes, please list:……… ❒ Yes ❒ No

____

____

11. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, latex, aspirin, codeine, or any other drugs or medicines? If yes, please list:……… ❒ Yes ❒ No

____

12. Have you ever had excessive bleeding requiring special treatment?……… ❒ Yes ❒ No

13.Do you use any tobacco products?……… ❒ Yes ❒ No

14.When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?……… ❒ Yes ❒ No

15.Do your ankles swell during the day?……… ❒ Yes ❒ No

16.Have you lost or gained more than 10 pounds in the last year?……… ❒ Yes ❒ No

17.Do you use more than 2 pillows to sleep?……… ❒ Yes ❒ No

18.Do you ever wake up from sleep short of breath?……… ❒ Yes ❒ No

19.Are you on a special diet?……… ❒ Yes ❒ No

MEDICAL HISTORY (CONT.)

20.Check any of the following which apply in either past or present:

- ❒ Heart Valve Prolapse
- ❒ Heart Failure
- ❒ Heart Disease or Attack
- ❒ Family History of Cardiovascular Disease
- ❒ Angina Pectoris (chest pain)
- ❒ Rheumatic Fever
- ❒ Congenital Heart Lesions
- ❒ Scarlet Fever
- ❒ Artificial Heart Valve
- ❒ Heart Pacemaker
- ❒ Heart Surgery
- ❒ Artificial Joint of Any Type
- ❒ Diet Medication: Name_______________
- ❒ Heart Murmur
- ❒ Bruise Easily
- ❒ Blood Transfusion
- ❒ Hemophilia
- ❒ Sickle Cell Disease
- ❒ High Blood Pressure
- ❒ Anemia
- ❒ Asthma
- ❒ Emphysema
- ❒ Shortness of Breath
- ❒ Hay Fever
- ❒ Allergies or Hives
- ❒ Fainting or Dizzy Spells
- ❒ Epilepsy or Seizures
- ❒ Nervousness
- ❒ Psychiatric Treatment
- ❒ Any Form of Eating Disorder
- ❒ Recreational Drug Use
- ❒ Drug Addiction/Alcoholism
- ❒ Tuberculosis (TB)
- ❒ Any Form of Hepatitis
- ❒ Liver Disease
- ❒ Rheumatism
- ❒ Cortisone Medication
- ❒ Arthritis
- ❒ Pain in Jaw Joints
- ❒ X-Ray or Cobalt Treatment
- ❒ Cancer or Tumors
- ❒ Chemotherapy (Cancer, Leukemia)
- ❒ Thyroid Disease
- ❒ Glaucoma
- ❒ HIV Positive (AIDS)
- ❒ Venereal Disease
- ❒ Cold Sores or Fever Blisters
- ❒ Genital Herpes
- ❒ Kidney Trouble
- ❒ Diabetes
- ❒ Ulcers
- ❒ Stroke
- ❒ Birth Control Medication
- ❒ Pregnant – Due

Date_________________

21.Do you have any disease, condition or problem not listed? If so, please list.…………………………….….. ❒ Yes ❒ No

____

____