Dr. James B. Hansen II, D.D.S., P.A.

COMPREHENSIVE GENERAL DENTISTRY

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Welcome to our practice! We thank you for making us your choice and joining with us in caring for your dental health. By becoming our patient, you have created a partnership which we hope will last through the years.

Our partnership is prevention oriented and dedicated to your health. We are committed to providing superior dental care and are proud of our dedication to our patients. Our goal is to help you feel and look your best while focusing on long term dental health.

Our office hours are patient-oriented and we are available for emergency services. Because communication is important, we will advise you of treatment needs and expenses in advance, even assist with your insurance filing. We are here to serve you so please do not hesitate to contact us regarding any matter.

We welcome new patients and appreciate any referrals we might earn. Our practice again welcomes you and looks forward to a long and healthy partnership with you, your family and friends.

Best regards

James B. Hansen II, DDS

PATI E NT I N FORMATION

Date _____

SS/HIC/Patient 10 # _____ _

Patient _____ _

Address, _____ _

City _____

State _____ _ Zip _____

E-mail _____

Sex D M D F Age _____ _

Birth date _____

_Married _Widowed _Single _Minor

_Separated _Divorced _Partnered for _____ years

Occupation _____

Patient Employer/School _____ _

Employer/School Address _____ _

Employer/School Phone (_____) _____

Spouse's Name _____

Birth date _____ _

SS# _____ _

Spouse's Employer _____ _

Whom may we thank for referring you? _____ _

DENTAL INSURANCE

Who is responsible for this account? _____ _

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient *covered* by additional insurance? _Yes _ No

Subscriber's Name _____ _

Birth date _____ 8S# _____ _

Relationship to Patient _____ _

Insurance Co. _____

Group #

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____Name of Insurance Company_____ and assign directly to

Dr. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date Relationship to Patient

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ _ Ext Cell Phone (_____) _____ _

Spouse's Work (_____) Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not *live* in your household.)

Name _____ _ Relationship _____ _

Home Phone (_____) _____ _ Work Phone (_____) _____ _

DENTAL HISTORY

PLEASE CIRCLE ALL THAT APPLY

Reason for today's *visit* _____ –

Former Dentist _____ _

Citv/State _____

Date of last dental *visit* _____ _

Date of last dental X-rays _____ –

Place a mark on "yes" or "no" to indicate if you *have* had any of the following:

Bad breath _Yes _No

Bleeding gums _Yes _No

Blisters on lips or mouth _Yes _No

Burning sensation on tongue	Yes	No	Mouth breathing	Yes	No
Chew on one side of mouth	Yes	No	Mouth pain, brushing	Yes	No
Cigarette, pipe, or cigar smoking	Yes	No	Orthodontic treatment	Yes	No
Clicking or popping jaw	Yes	No	Pain around ear	Yes	No
Dry mouth	Yes	No	Periodontal treatment	Yes	No
Fingernail biting	Yes	No	Sensitivity to cold	Yes	No
Food collection between the teeth	Yes	No	Sensitivity to heat	Yes	No
Foreign objects	Yes	No	Sensitivity to sweets	Yes	No
Grinding teeth	Yes	No	Sensitivity when biting	Yes	No
Gums swollen or tender	Yes	No	Sores or growths in your mouth	Yes	No
Jaw pain or tiredness	Yes	No	How often do you floss? _____		
Lip or cheek biting	Yes	No			
Loose teeth or broken fillings	Yes	No	How often do you brush? _____		

– OVER –

HEALTH HISTORY

Physician's Name _____ Date of last visit _____ _

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). DYes D No

Please mark a "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	_Yes	_No	Epilepsy	_Yes	_No	Respiratory Disease	_Yes	_No
Anemia	_Yes	_No	Fainting or dizziness	_Yes	_No	Rheumatic Fever	_Yes	_No
Arthritis, Rheumatism	_Yes	_No	Glaucoma	_Yes	_No	Scarlet Fever	_Yes	_No
Artificial Heart Valves	_Yes	_No	Headaches	_Yes	_No	Shortness of Breath	_Yes	_No
Artificial Joints	_Yes	_No	Heart Murmur	_Yes	_No	Sinus Trouble	_Yes	_No
Asthma	_Yes	_No	Heart Problems	_Yes	_No	Skin Rash	_Yes	_No
Back Problems	_Yes	_No	Hepatitis Type	_Yes	_No	Special Diet	_Yes	_No
Bleeding abnormally, with extractions or surgery	_Yes	_No	Herpes	_Yes	_No	Stroke	_Yes	_No
			High Blood Pressure	_Yes	_No	Swollen Feet or Ankles	_Yes	_No
Blood Disease	_Yes	_No	Jaundice	_Yes	_No	Swollen Neck Glands	_Yes	_No
Cancer	_Yes	_No	Jaw Pain	_Yes	_No	Thyroid Problems	_Yes	_No
Chemical Dependency	_Yes	_No	Kidney Disease	_Yes	_No	Tonsillitis	_Yes	_No
Chemotherapy	_Yes	_No	Liver Disease	_Yes	_No	Tuberculosis	_Yes	_No
Circulatory Problems	_Yes	_No	Low Blood Pressure	_Yes	_No	Tumor or growth on head or neck	_Yes	_No
Congenital Heart Lesions	_Yes	_No	Mitral Valve Prolapse	_Yes	_No			
Cortisone Treatments	_Yes	_No	Nervous Problems	_Yes	_No	Ulcer	_Yes	_No
Cough, persistent or bloody	_Yes	_No	Pacemaker	_Yes	_No	Venereal Disease	_Yes	_No
Diabetes	_Yes	_No	Psychiatric Care	_Yes	_No	Weight Loss, unexplained	_Yes	_No
Emphysema	_Yes	_No	Radiation Treatment	_Yes	_No			
Do you wear contact lenses?	_Yes	_No						

Women:

Are you pregnant? _Yes _No Due date

Are you nursing? _Yes __No

Taking birth control pills? _Yes _No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

ALLERGIES

_ Aspirin

_ Barbiturates (Sleeping pills)

_ Codeine

_ Iodine

_ Latex

_Local Anesthetic

_ Penicillin

_Sulfa

_ Other _____ _

Pharmacy Name

Phone (__) _____ _

(To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? _Yes No

For what conditions?

Are you taking any new medications? If so, what?

Patient's Signature _____ Date _____ _

Doctor's Signature _____ _ Date _____ _

Has there been any change in your health since your last dental appointment? _Yes _ No

For what conditions?

Are you taking any new medications? _____ If so, what? _____ _

Patient's Signature _____ Date _____ _

Doctor's Signature _____ _ Date _____ _

DR, JAMES B. HANSEN. II. DDS PA.
DR, KEITH RILEY, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIV ACY PRACTICES

. You May Refuse to Sign This Acknowledgement

1, _____ have received a copy of this office's Notice Of Privacy Practices;

Please Print Name: _____ _

Signature: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because

Individual refused to sign

Communications barriers prohibited obtaining acknowledgement

Emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)