

**William A. Hall, Jr., D.D.S., L.L.C.**  
**Eric N. Hall, D.M.D.**  
4104 Arkwright Road  
Macon, GA 31210

**PATIENT INFORMATION**

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ SSN: \_\_\_\_\_  
LAST, FIRST, MI

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_

Spouse: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ SSN: \_\_\_\_\_

Spouse (Place of Employment): \_\_\_\_\_ Spouse (Work Phone): \_\_\_\_\_ (Cell): \_\_\_\_\_

Whom may we thank for referring you to our practice? \_\_\_\_\_

**HEALTH INFORMATION AND HISTORY**

**Emergency Contact: (If not listed above)**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Primary Physician:** \_\_\_\_\_ Phone: \_\_\_\_\_ City & State: \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_ Date of last blood test/work up: \_\_\_\_\_

**Other Physicians & Specialists**

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_ City & State: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_ City & State: \_\_\_\_\_

1. **With in the last 3 years, have you been hospitalized or had surgery?**  Yes  No

If Yes, please give reasons and dates: \_\_\_\_\_

2. **Have you ever been instructed to take ANY medications or take ANY special precautions before any dental appointments\*?**  Yes  No

If Yes, please explain: \_\_\_\_\_

3. **Are you taking ANY drugs, medications, or treatments at this time?**  Yes  No

(If you brought a complete written list with you, give that to the receptionist instead)

Prescribed: \_\_\_\_\_

Over-the-counter (OTC) medications (such as Aspirin, Advil, allergy medication, sleeping aids, etc):  
\_\_\_\_\_

Vitamins, natural or herbal preparations and/or dietary supplements:  
\_\_\_\_\_

Are you having or have you ever had radiation or chemotherapy treatments\*?  Yes  No

If Yes, for how long? \_\_\_\_\_ Name of facility performing the treatment: \_\_\_\_\_

4. **Are you taking or have you ever taken / been treated with a Bisphosphonate (Fosamax)?**  Yes  No

## HEALTH INFORMATION AND HISTORY, CONTINUED

**5. Are you allergic to or have you ever experienced an unusual reaction to:**

- Latex                       Metals or jewelry                       Dental anesthesia (local)  
 Fluoride                       Nitrous oxide (laughing gas)                       General anesthesia

**6. Are you allergic to or have you ever had any reaction to any of the following drugs?**

- Penicillin (or related drugs)                       Tranquilizers (Valium)                       Tetracycline                       Codeine  
 Aspirin / Ibuprofen (Advil, Motrin, Nuprin)                       Keflex (Cephalexin)                       Sulfa drugs                       Iodine  
 NSAID (Celebrex, Vioxx, Anaprox)                       Clindamycin (Cleocin)                       Erythromycin

**7. Have you had an allergic reaction or unusual response to ANY other medications, drugs, pills, or treatments?**

Yes     No

If Yes, please list : \_\_\_\_\_

**8. Do you have, or have you ever had, any of the following? (Please check Yes or No for each question)**

	Yes	No		Yes	No
Congenital heart defects	___	___	Asthma	___	___
Angina or chest pains	___	___	Hay fever, skin or food allergies or allergies in general	___	___
Atherosclerosis	___	___	Sinus problems	___	___
Congestive heart failure	___	___	Tuberculosis, emphysema or lung disorder	___	___
Coronary artery disease	___	___	Skin problems	___	___
Heart surgery	___	___	A sore or wound that bleeds easily or does not heal	___	___
If Yes, type & date _____			A thyroid problem or disease	___	___
Heart attack	___	___	Arthritis	___	___
If Yes, date _____			Glaucoma or any eye diseases	___	___
Rheumatic heart disease / rheumatic fever	___	___	Epilepsy or other seizure disorder	___	___
Infective Endocarditis*	___	___	Any kidney problems	___	___
Heart valve(s) damage / Mitral valve prolapse	___	___	Ulcers, acid reflux, or stomach problems	___	___
Artificial heart valve	___	___	A compromised immune system (Lupus, HIV, AIDS, radiation immune problem, etc.)	___	___
Pacemaker	___	___	An active sexually transmitted disease (STD)	___	___
Stroke or CVA	___	___	Any mental health issues	___	___
High blood pressure	___	___	Been treated for any psychiatric condition	___	___
Low blood pressure	___	___	<b>Women Only:</b>	<b>Yes</b>	<b>No</b>
Anemia	___	___	Are you pregnant	___	___
Hemophilia or bleeding disorder	___	___	If Yes, what is your due date: _____		
Excessive bleeding from any cut or incident	___	___	Do you think you might be pregnant	___	___
Diabetes or blood sugar problems	___	___	Are you presently nursing	___	___
Any artificial joint, joint surgery, or prosthesis	___	___	Are you using birth control medication	___	___
If Yes, what joint or area: _____			Are you taking hormone replacement therapy	___	___
When was operation done: _____					
Hepatitis, jaundice, or other liver problems	___	___			
Any form of cancer	___	___			
An organ transplant	___	___			

**9. Do you have any other conditions, diseases, or medical problems, or is there ANY other information that you would like us to know about, or that we should be made aware of?**

Yes     No

If Yes, please explain: \_\_\_\_\_

## Dental and Oral Health Information

Patient's name: \_\_\_\_\_ Date: \_\_\_\_\_

Please describe any specific dental problem or discomfort you are having at this time: \_\_\_\_\_

How long has it been present? \_\_\_\_\_

If you have had any of the following dental care please list the dentists and approximate dates:

Periodontal (gum) treatment or surgery \_\_\_\_\_

"Braces" or any type of orthodontic treatment: \_\_\_\_\_

Dental implants: \_\_\_\_\_

Any other type of oral surgery: \_\_\_\_\_

Do you have / have you had / have you noticed any of the following signs or symptoms in your head, neck, or mouth?

(Please check Yes or No for each question)	Yes	No		Yes	No
Teeth that are sensitive to:			A clicking, snapping or difficulty when chewing	___	___
Hot, cold, sweets, or biting pressure	___	___	Difficulty opening or moving the jaws	___	___
An unpleasant taste or persistent bad breath	___	___	Difficulty speaking or changes in your voice	___	___
Does food catch between your teeth	___	___	Difficulty moving your tongue or "tongue tied"	___	___
Do your gums bleed when brushing	___	___	Loose or separating teeth	___	___
Red, swollen, tender, bleeding, or sore gums	___	___	Changes in the way your teeth fit together	___	___
Gums that have pulled away from the teeth	___	___	A color change of the tissues in your mouth	___	___
Pus between the teeth and gums	___	___	Pain, tenderness, numbness, or earaches	___	___
Avoid any area when brushing or chewing	___	___	Any lumps, swelling or swollen glands	___	___
You clench or grind your teeth	___	___	Sores, ulcers, or rough spots in your mouth	___	___

### Your Dental Health:

How do you rate your overall dental health?  Good  Fair  Poor

How many times a day do you brush your teeth? \_\_\_\_\_ How many times a week do you floss your teeth? \_\_\_\_\_

Do you use any of the following? (Please check Yes or No for each question) Yes No

Mechanical (electric) toothbrush	If Yes, what type or brand? _____	___	___
Flossing aids (floss holders, threaders, etc.)	_____	___	___
Oral irrigating device (Waterpik)	_____	___	___
Fluoride treatments or supplements at home. If Yes, which ones:	_____	___	___
Mouthwashes or oral rinses. If Yes, what brand?	_____	___	___

Do you have any missing teeth that have not been replaced? \_\_\_

Why have you not had them replaced? \_\_\_\_\_

Do you wear any removable dental appliances? \_\_\_

If Yes, what type and for how long? \_\_\_\_\_

Have you ever had your teeth whitened or bleached? \_\_\_

Would you like to have your teeth whitened or bleached? \_\_\_

How do you feel about the appearance of your smile and what would you change if you could? \_\_\_\_\_

Are you concerned about the finances required to return your mouth to excellent health? \_\_\_

Are you frustrated because you always need something treated or repaired when you visit a dentist? \_\_\_

Do you feel you will eventually wear artificial dentures? \_\_\_

Have you ever had any complications from an extraction or dental treatment? \_\_\_

If Yes, please explain: \_\_\_\_\_

Have you ever had any other dental conditions, major trauma or injury to your head, neck, or mouth? \_\_\_

If Yes, please specify: \_\_\_\_\_

If you are a new patient to this practice:

Date of last dental visit \_\_\_\_\_ Dentist's name \_\_\_\_\_ City & State \_\_\_\_\_

# Oral Health Risk Factors

Patient's Name: \_\_\_\_\_

1. Do you smoke or have you **EVER** smoked?  Yes  No  
(If No, proceed to question 2)

The amount that you are presently smoking (Check **ALL** that apply)

- None (quit smoking completely)     Less than 1 pack of cigarettes per day     An occasional cigar  
 An occasional cigarette     1-2 Packs of cigarettes per day     Cigars on a daily / regular basis  
 A few cigarettes per Day     2 or more packs of cigarettes per day     Occasional pipe smoker  
 A pipe on a daily / regular Basis

If you have quit smoking, when did you quit?

- Less than 6 months ago     6 months to a year ago     1 to 3 years ago     Over 3 years ago

How many years have you or did you smoke?

- Less than 2 years     2-5 years     5-10 years     10-20 years     Over 20 years

2. Do you / Have you **EVER** chew/chewed tobacco or use/used snuff or other similar substance?  Yes  No  
(If No, proceed to question 3)

Are you **STILL** using smokeless tobacco or snuff?  Yes  No

If No, **WHEN** did you quit?

- Less than 6 months ago     6 months to a year ago     1 to 3 years Ago     Over 3 years ago

How many years did you use or have you used smokeless tobacco?

- Less than 1 year     1-2 years     2-5 years     Over 5 years

3. Approximate average amount of alcoholic beverages presently consumed per week:

- None     Less than 1 per week     1-5 drinks     6-11 drinks     11-20 drinks     Over 20 drinks

4. Do you have or have you ever had a substance abuse problem?  Yes  No

Describe \_\_\_\_\_

5. Do you presently use any recreational drugs?  Yes  No

List \_\_\_\_\_

6. Do you have or have you ever had an eating disorder?  Yes  No

If Yes, Please Specify: \_\_\_\_\_

7. Do you have or have you ever had any head, neck or mouth piercing(s)? (Other than ears)  Yes  No

List \_\_\_\_\_

8. Do you have or have you ever been informed that you have been infected with an oncogenic strain (possible cancer-causing) of the Human Papilloma Virus (HPV)?  Yes  No

9. Please list your history or any family member's history of cancer:

\_\_\_\_\_  
\_\_\_\_\_

10. Other concerns and considerations:

\_\_\_\_\_  
\_\_\_\_\_

CONSENT—To the best of my knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Parent or guardian, if patient is a minor)

Reviewed By: \_\_\_\_\_

**Notice of Privacy Practices Acknowledgement**  
**William A. Hall Jr., D.D.S., L.L.C.**  
**4104 Arkwright Rd.**  
**Macon, Ga. 31210**

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclose to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_