Hereford Dental Health
Craig Longenecker DDS

WELCOME

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.
The better we communicate, the better we can care for you.

1 ABOUT YOU

Name _____

Preferred Name _____ ❑ Male ❑ Female

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Birthdate ___/___/___ Age ____ SS # ___-___-____

Address _____

City _____ State _____ Zip _____

Email _____

Home # _____ Work # _____

Mobile # _____ Fax # _____

Whom may we thank for referring you? _____

Other family members seen by us _____

Last visit date _____

Employer _____ Employer Ph # _____

Employer Address _____

How long employed there? _____

SPOUSE INFO

Name _____

Home # _____ Work # _____

Mobile # _____ Birthdate ___/___/___

Email _____

2 ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____

Home # _____ Work # _____

Mobile # _____ Birthdate ___/___/___

Email _____

Billing Address _____

City _____ State _____ Zip _____

SS# _____

Thank you for filling out this form completely. It will allow us to serve you more effectively. If you have a question at any time, please ask us. We are happy to help.

3 INSURANCE

Provider Name _____

Provider Address _____

City _____ State _____ Zip _____

Phone # _____

Group # _____

ID# _____

Insured's Name _____

Relation _____

Insured's Birthdate _____

Insured's Employer _____

Insured's Ph# _____

Insured's SS# _____

**ID# is sometimes different that SS#*

IF YOU HAVE A SECONDARY INSURANCE PLEASE LET A TEAM MEMBER KNOW.

4 REMINDER INFO

Because we know your life is busy, we use an Electronic Appointment Reminder and Messaging System. Please check all that you prefer, as our best way to contact you.

❑ Email Only ❑ Text Message Only ❑ Text Message & Email
❑ Personal Phone Call ❑ Don't Need A Reminder
❑ Home ❑ Work ❑ Cell

5 CONTACT INFO

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name _____ Relation _____

Home # _____ Work # _____

6 MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name _____

Phone # _____ Last visit date _____

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain _____

_____

Your current physical condition ❑ Good ❑ Fair ❑ Poor

Do you smoke or use tabacco in any form? ❑ Yes ❑ No

Are you taking any prescription/over-the-counter or herbal supplement drugs? ❑ Yes ❑ No

Please list each one: _____

_____

_____

_____

Have you ever taken Phen-Fen? ❑ Yes ❑ No

(Also known as Redux or Pondimin) If yes, when? _____

Are you taking any medications for Osteoporosis? ❑ Yes ❑ No

If so, what? _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Aspirin	Yes	No	Erythromycin	Yes	No	Penicillin	Yes	No
Codeine	Yes	No	Jewelry/Metals	Yes	No	Tetracycline	Yes	No
Dental Anesthetics	Yes	No	Latex	Yes	No	Other	Yes	No

Please list any other drugs/materials that you are allergic to:

_____

_____

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Abnormal Bleeding	Yes	No	Herpes/Fever Blisters	Yes	No
A / Drug Abuse	Yes	No	High Blood Pressure	Yes	No
Anemia	Yes	No	HIV+ / AIDS	Yes	No
Arthritis	Yes	No	Hospitalized for any reason	Yes	No
Artificial Bones, Joints, or Valves	Yes	No	Kidney Problems	Yes	No
Asthma	Yes	No	Liver Disease	Yes	No
Blood Transfusion	Yes	No	Low Blood Pressure	Yes	No
Cancer/Chemotherapy	Yes	No	Lupus	Yes	No
Colitis	Yes	No	Mitral Valve Prolapse	Yes	No
Congenital Heart Defect	Yes	No	Pacemaker	Yes	No
Diabetes	Yes	No	Psychiatric Problems	Yes	No
Difficulty Breathing	Yes	No	Radiation Treatment	Yes	No
Emphysema	Yes	No	Rheumatic/	Yes	No
Epilepsy	Yes	No	Scarlet Fever	Yes	No
Fainting Spells	Yes	No	Seizures	Yes	No
Frequent Headaches	Yes	No	Shingles	Yes	No
Glaucoma	Yes	No	Sickle Cell Disease	Yes	No
Hay Fever	Yes	No	Sinus Problems	Yes	No
Heart Attack	Yes	No	Stroke	Yes	No
Heart Murmur	Yes	No	Thyroid Problems	Yes	No
Heart Surgery	Yes	No	Tuberculosis (TB)	Yes	No
Hemophilia	Yes	No	Ulcers	Yes	No
Hepatitis	Yes	No	Venereal Disease	Yes	No

Please list any medical condition(s) that you have ever had:

_____

_____

FOR WOMEN ONLY

Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week # _____

Are you nursing? ❑ Yes ❑ No

7 DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

_____

_____

_____

Has your doctor told you that you require antibiotics before dental treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had a serious/difficult problem associated with with any previous dental work? ❑ Yes ❑ No

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of toothbrush bristles? ❑ Hard ❑ Medium ❑ Soft

8 DISCLAIMER

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I amy need during diagnosis and treatment with my informed consent.

In the event that payment in full for charges incurred is not made, I agree to pay all costs of collection including a 50% collection fee, attorney fees and court costs.

_____

Signature Date

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

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