Nicholas L. Hammermeister, D.D.S., Inc.

First Name _____ M.I. ____ Last _____ Preferred _____
Social Security # _____ Birthdate _____/ _____/ _____ Sex M / F
Street Address _____ Home Phone ( ) _____
City _____State _____Zip_____ Cell Phone ( ) _____
Patient's Employer _____E-mail _____
Employer Address_____City/State_____Zip_____Work Ph. _____
If patient is a student, Name of School/College _____
Marital Status ( ) Single ( ) Married ( )Separated ( )Divorced ( ) Widowed
Spouses Name_____ Spouse's Soc sec# _____
Spouse's Employer_____ Employer's Phone # _____
Person to contact in case emergency_____ Phone _____
Who may we thank for referring you? _____
IF SPOUSE, PARENT OR GUARDIAN IS LIABLE FOR ACCOUNT, FILL OUT THE FOLLOWING:
Responsible Party's Name _____ Birthdate _____
Address_____ Phone_____
Party's Employer_____ Years Employed _____ SS# _____
Employer's Address _____ Phone _____
Name of Dental Insurance _____Co-insurance _____ Group # _____

Medical History

Physician's Name _____Phone # _____
Have you ever had any serious illnesses or operations? _____
Are you pregnant? _____ Are you nursing? _____ Are you taking birth control pills? _____

Please check if you have or have had any of the following:

( ) Arthritis
( ) Artificial Heart Valve
( ) Asthma
( ) Bleeding Problems/Blood Disease
( ) Blood Transfusion
( ) Cancer
( ) Chemical Dependency
( ) Chemotherapy
( ) Circulatory Problems
( ) Diabetes
( ) Epilepsy/Seizures
( ) Fainting
( ) Heart Murmur
( ) Heart Problems
Describe_____
( ) Hepatitis
( ) High Blood Pressure
( ) HIV+/ AIDS
( ) Jaw Pain
( ) Latex Allergy
( ) Pacemaker
( ) Psychiatric Care
( ) Osteoporosis/Bone Disease
( ) Radiation Treatment
( ) Respiratory/Lung Disease
( ) Rheumatic Fever or
( ) Rheumatic Heart Disease
( ) Scarlet Fever
( ) Sexually Transmitted Dis
( ) Shortness of Breath
( ) Thyroid Problems
( ) Tobacco Habit
( ) Tuberculosis
( ) Ulcers

Please List Medications you are currently taking.

Medications	Reason
1._____	
2._____	
3._____	
4._____	
5._____	
6._____	

Please list any allergies.

_____
_____
_____
_____
_____
_____

I certify that I have answered all the questions to the best of my knowledge. I authorize the dentist to release any information regarding my treatment or my child's treatment to third party payers and/or health practitioners. I understand that my insurance company may **pay** less than the actual bill. I agree to be responsible for payment of all services.

SIGNATURE _____ **DATE** _____