Hackney Family Dentistry

1051 SE State Route 3 • Shelton, WA 98584 • 360-426-1676 • www.drhackney.com

Date _____

Name _____ Birthdate ____/____/____ M/F _____ Marital Status _____

Home Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Email _____

Employer _____ Employer Address _____

Person Responsible for Account _____ Relationship to Patient _____

Name of Spouse, Parent, Guardian (circle one) _____

Spouse's Occupation _____ Employer _____ Work Phone _____

Nearest Relative not living with you _____ Relationship _____

Address _____ Home Phone _____ Work Phone _____

Dental Insurance Company _____ SSN _____ Group No. _____

Spouse's Insurance Company _____ SSN _____ Birthdate ____/____/____

Referred by _____ Date of last dental cleaning _____ Date of last dental check-up _____

Please Check	**Yes**	**No**
1. Are you happy with the appearance of your teeth?	____	____
2. Are you interested in keeping your teeth for the rest of your life?	____	____
3. Are you worried about receiving dental treatment?	____	____
4. Do you have sensitive teeth?	____	____
5. Do you have bleeding gums?	____	____
6. Have you ever been diagnosed with periodontal disease?	____	____
7. Have you ever had sores or growths in the mouth or on the lips that are slow to heal?	____	____
8. Do you have difficulty opening your mouth or any trouble with your jaw joint?	____	____
9. Have you had surgery or been hospitalized in the last 2 years?	____	____
10. Are you currently taking any medications?	____	____
If yes, please list below		
_____		
_____		
_____		
_____		
11. Are you pregnant?	____	____
12. Are you being treated for any condition by a physician?	____	____
Physician _____		
Phone _____		
Date of last check-up _____		
13. Do you use Tobacco?	____	____
14. Are you interested in quitting?	____	____

15. Have you had?	**Yes**	**No**
Heart attack	____	____
Pacemaker	____	____
Heart Valve replacement	____	____
High blood pressure	____	____
Low blood pressure	____	____
Other heart ailment	____	____
Respiratory disease	____	____
Tuberculosis	____	____
Stroke	____	____
Kidney infection	____	____
Liver infection	____	____
Hepatitis	____	____
Epilepsy	____	____
Diabetes	____	____
Arthritis	____	____
Radiation/Chemo treatment	____	____
Sinus trouble	____	____
Joint replacement	____	____
Frequent headaches	____	____
Prolonged bleeding	____	____
Sleep Apnea	____	____
Latex sensitivity / Allergy	____	____

Please list any other Allergies

_____

_____

Office Staff Use

Health History Reviewed

Date Signature

_____

Your Signature _____ Date _____