J. Stephen Hoard
1421 S. Glenburnie Road New Bern, NC 28562 (252)633-9800

Name:_____ Preferred Name:_____
Social Security#_____ Sex M or F Birthdate:_____
Address:_____
Phone: Home:_____ Work:_____ Cell:_____
Marital Status:_____ Spouse's Name:_____ Spouse's Birthdate_____

Employer:_____ Phone:_____
Employer's Address_____
Is dental insurance thru above employer? Yes No
Spouse's Employer_____

Dental Insurance Carrier_____
Subscriber:_____
Carrier Address:_____
Group#_____ Policy#_____
I authorize my doctor to act as my agent to obtain payment for my insurance carrier. Signed:_____

Previous Dentist
Name:_____
Address:_____
Telephone:_____

Acknowledge of financial responsibility- This information is accurate and true to the best of my knowledge. I understand that I am responsible for services rendered, including reasonable collection fees in the event of default, I further understand that if payment becomes 30 days past due, finance charges of 18% will be added to past due amounts from the date payment was due.

Signature:_____

Acknowledgement of receipt of Notice of Privacy Practices

I,_____, have received a copy of Dr. Hoard's privacy practices. (Enclosed in Folder)

Signed:_____

Date:_____

Patient Name:_____

Welcome! So that we can provide you with the best possible care, please complete all of these forms to establish a medical /dental history. All of this information is completely confidential.

Have you been under the care of a physician during the past two years?_____
If yes, for what?_____

Have you taken any medication or drugs in the past two years?_____

Are you taking any medication, drugs, or pills now, including regular doses of aspirin?_____
Please List:_____

Have you ever taken prescription medication for weight loss?_____
If yes, did you take any of the following? Podimen Redux Fen-Phen
If yes, have you had a medical exam for heart related issues?_____

Are you aware of having an allergic (or adverse) reaction to any medication or substance?_____
If Yes, Please list:_____

Do you consider yourself to be under a lot a stress at this time?_____

Indicate which one of the following you have had, or have at the present. Circle yes or no for each.

Heart (Disease, Surgery, Attack)	Y N	Ulcers	Y N	Hepatitis A, B, or C	Y N
Mitral Valve Prolapse	Y N	Diabetes	Y N	Venereal Disease	Y N
Heart Murmur	Y N	Thyroid Problems	Y N	A.I.D.S.	Y N
Artificial Heart Valve	Y N	Emphysema	Y N	H.I.V. Positive	Y N
Chest Pain	Y N	Chronic Cough	Y N	Blood Transfusion	Y N
Congenital Heart Disease	Y N	Tuberculosis	Y N	Hemophilia	Y N
Rheumatic Fever	Y N	Asthma	Y N	Bruise Easily	Y N
Artificial Joint (knee, hip, etc.)	Y N	Latex Sensitivity	Y N	Neurological Disorders	Y N
Arthritis/Rheumatism	Y N	Stroke	Y N	Epilepsy or Seizures	Y N
Radiation/Chemo Therapy	Y N	Sinus Trouble	Y N	Nervous Anxious	Y N
High Blood Pressure	Y N	Fainting/Dizzy Spells	Y N	Psychological Care	Y N

Do you have or have you had any disease, condition, or problem not listed? _____
If yes, please list:_____

Women : Are you: Pregnant? Yes, ____months No Nursing? Yes No Birth Control Pills ?Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of knowledge. Should further information be needed, you have my permission to ask respective health care provider or agency , who may release such information to you. I will notify the doctor of any change in my health or medication.
Patient/Guardian:_____Date:_____

Name:_____

J. Stephen Hoard, IV

On a scale of 1-10, how would you rate your teeth's appearance? 1 2 3 4 5 6 7 8 9 10
Is there anything you would change about your teeth?_____

_____

Would you like to keep your teeth all of your life?_____
Are you happy with the color of your teeth?_____
Have you ever whitened your teeth?_____
Do you smoke?_____How much?_____
Do you use smokeless tobacco? _____How Often?_____
Do your gums bleed or hurt?_____
Do you have any mouth odors or bad tastes?_____
Do you frequently get cold sores/fever blisters?_____
Do you get mouth ulcers frequently?_____
Are any of your teeth sensitive to Hot? _____Cold?_____Sweets?_____
Biting?_____Chewing?_____
Have you ever had Orthodontic treatment? (Braces)_____
Have you ever had periodontal treatment? (Gum disease)_____
Have you ever had oral surgery?_____
Do you have an area in your mouth where food gets caught?_____
Do you have any loose or broken fillings?_____
Do you have any missing teeth?_____
Have they been replaced?_____
Do you have any fixed bridges?_____Removable partials?_____
Dentures?_____Dental implants?_____
Are you comfortable with the replacements?_____
Have you noticed any change in your teeth?_____
Have you noticed any change in your bite?_____
Can you chew on both sides of your mouth?_____
Have you ever had a trauma to your Jaw?_____
When?_____Was it the result of an accident?_____
Has your jaw ever locked open?_____Closed?_____When?_____
For how long?_____
Does your face feel tired after talking all day?_____
Does your face feel tired after chewing?_____
Does your face hurt when you wake up in the morning?_____
Or in the afternoon?_____Or at night?_____
Have you ever been bothered with noises in your jaw joints?_____
Describe:_____
Does your jaw make noises now?_____
Which side?_____Does your jaw click?_____Pop?_____
Do you have ringing in your ears?_____
DO you grind or clench your teeth?_____
How often?_____At night?_____During the day?_____
Do you have headaches?_____IF yes, please turn sheet over.

When do you experience most of your headaches? _____A.M. _____P.M.

Where do you experience most of your headaches? Please mark circles on the diagram. (temples, jaw area, forehead, top of head, sides of the head)