Hohenstein & Schwartz
FAMILY & COSMETIC DENTISTRY

Today's Date: _____

Name: _____ I prefer to be addressed as: _____ ☐ Male ☐ Female
Last First MI Mr. Mrs. Ms. Dr.

Birth date: ____/____/____ Age: _____ Social Security #:_____ Employer/Occupation: _____

Home Address: _____
Street City State Zip

Home Phone #: (____) _____Work Phone #: (____) _____ Ext. _____ Cell Phone # :(____) _____

Email: _____ How would you like us to confirm appointments? ☐**Home** ☐**Cell** ☐**Work** ☐**Email**

Whom may we thank for referring you? _____

Spouse OR Parent Information

His/ Her Name: _____ Work/Cell Phone # (_____) _____

Dental Insurance Information

Dental Coverage? **Yes** **No** If yes, must be completely filled out. If no, person responsible for this account: _____

Primary Dental Insurance Co. Name: _____ Phone #: (_____) _____

Insured's Name: _____ Insured's Social Security #: _____ ID #: _____

Insured's Birthdate: ____/____/____ Relation: _____Insured's Employer: _____

Insurance Address:_____
Street/ PO Box City State Zip

Secondary Dental Insurance Co. Name: _____ Phone#: (_____) _____

Insured's Name: _____ Insured's Social Security#: _____ ID#: _____

Insured's Birthdate: _____/____/_____ Relation: _____Insured's Employer: _____

Insurance Address: _____
Street/ PO Box City State Zip

Dental History

Are you currently in pain? **Yes** **No**

How is your current dental health? **Excellent** **Good** **Fair**

How often do you floss? _____ Brush? _____

Type of bristles on your toothbrush? **Hard** **Medium** **Soft**

Have you ever been told to take an antibiotic before treatment? **Yes** **No**

Would you like fresher breath? **Yes** **No** Whiter teeth? **Yes** **No**

Are you happy with the way your smile looks? **Yes** **No**

If not, what would you change? _____

Do your gums bleed? **Yes** **No**

Have you had periodontal disease? **Yes** **No**

Previous/ Present Dentist: _____

Address: _____

_____

Phone number (_____) _____

Date of Last Exam: _____

Date of Last Cleaning: _____

Date of Last X-rays: _____

Would you like our office to request your X-rays? **Yes** **No**

Other side please →

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive.

Are you under a physician's care now? **Yes No** Physician's name and number: _____

Date of last physical: _____

Have you ever been hospitalized or had a major operation? **Yes No** If yes, please explain: _____

_____

Have you ever had a serious head or neck injury? **Yes No** If yes, please explain: _____

_____

Are you taking any medications, pills, or drugs? **Yes No** If yes, please list: _____

_____

Do you take, or have taken, any osteoporosis medications? **Yes No** If yes, please list: _____

Do you take, or have taken, any blood thinning medications? **Yes No** If yes, please list: _____

Are you on a special diet? **Yes No**

Do you use tobacco? **Yes No**

Women Only -Are you: Pregnant? ☐ Trying to get pregnant? ☐ Taking oral contraceptives? ☐ Nursing? ☐

Are you allergic to any of the following? Please circle: YES or NO IF YES, please indicate below.

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics ☐Other, please explain: _____

Do you have, or have you had, any following?

Yes No AIDS/HIV Positive	**Yes No** Drug Addiction	**Yes No** Irregular Heartbeat	**Yes No** Stomach Disease
Yes No Alzheimer 's Disease	**Yes No** Easily Winded	**Yes No** Kidney Problems	**Yes No** Stroke
Yes No Anaphylaxis	**Yes No** Emphysema	**Yes No** Leukemia	**Yes No** Swelling of Limbs
Yes No Anemia	**Yes No** Epilepsy or Seizures	**Yes No** Liver Disease	**Yes No** Thyroid Disease
Yes No Angina	**Yes No** Excessive Bleeding	**Yes No** Low Blood Pressure	**Yes No** Tonsillitis
Yes No Arthritis/Gout	**Yes No** Excessive Thirst	**Yes No** Mitral Valve Prolapse	**Yes No** Tuberculosis
Yes No Artificial Heart Valve	**Yes No** Fainting/Dizziness	**Yes No** Osteoporosis	**Yes No** Tumors or Growths
Yes No Artificial Joint	**Yes No** Frequent Cough	**Yes No** Pain in Jaw Joints	**Yes No** Ulcers
Yes No Asthma	**Yes No** Frequent Diarrhea	**Yes No** Parathyroid Disease	**Yes No** Yellow Jaundice
Yes No Atrial Fibrillation	**Yes No** Frequent Headaches	**Yes No** Psychiatric Care	
Yes No Blood Disease	**Yes No** Glaucoma	**Yes No** Radiation Treatments	
Yes No Bruise Easily	**Yes No** Hay Fever	**Yes No** Recent Weight Loss	
Yes No Cancer	**Yes No** Heart Trouble/Disease	**Yes No** Renal Dialysis	
Yes No Chemotherapy	**Yes No** Hemophilia	**Yes No** Rheumatic Fever	
Yes No Chest Pains	**Yes No** Hepatitis A, B or C	**Yes No** Rheumatism	
Yes No Congenital Heart Disorder	**Yes No** Herpes	**Yes No** Scarlet Fever	
Yes No Convulsions	**Yes No** High Blood Pressure	**Yes No** Sickle Cell Disease	
Yes No Cortisone Medicine	**Yes No** Hives or Rash	**Yes No** Sinus Trouble	
Yes No Diabetes	**Yes No** Hypoglycemia	**Yes No** Spina Bifida	

Have you ever had any serious illness not listed above? **Yes No** If yes, please explain: _____

_____

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status.

AUTHORIZATON:

I give my permission to use my personal health information to carry out treatment, payment or health care operations. I assign the Doctor all insurance benefits. **I understand that I am responsible for payment at the time of services, any deductible, and co-payment that my insurance does not cover.** I hereby authorize the use of radiographs, dental anesthesia, & generalized dental treatment.

*Patient has the right to review the provider's privacy notice. If you would like to review, or receive a copy of provider's privacy notice, please ask front desk. *Patient has the right to request restrictions.

We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice

Signature of patient (or parent/guardian for minor): _____ Date: _____