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 dentistry you will receive.

Are you under a physicians care now? **YES / NO** Physicians Name and Number: _____

Date of last physical: _____

Have you ever been hospitalized or had a major operation? **Please Explain**:

_____

_____

Have you ever had a serious head or neck injury? **Please Explain**:

_____

Are you taking any medications? **Please list ALL**:

_____

_____

Do you take, or have taken, any **osteoporosis medication**? Please list if yes: _____

Do you take, or have taken, any **blood thinning medication**? Please list if yes: _____

Are you on a special diet? _____

Do you use tobacco products? **YES / NO**

Women Only-

Are you: [ ] Pregnant [ ] Trying to get pregnant [ ] Taking oral contraceptives [ ] Nursing

Are you allergic to any of the following?

[ ] Aspirin **[ ]** Penicillin **[ ]** Codeine **[ ]** Acrylic **[ ]** Metal **[ ]** Latex **[ ]** Local Anesthetics **[ ]** Other: _____

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

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

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 staff.

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

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

Hohenstein & Schwartz
FAMILY & COSMETIC DENTISTRY

Name: _____ I prefer to be addressed as: _____ **[ ]**Male **[ ]** Female

Date of Birth: _____ Age: _____ Social Security # _____ Employer: _____

Mailing Address: _____ City: _____ State: _____ Zip code: _____

Home #: _____ Work #: _____ Cell #: _____

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

Whom may we thank for referring you? _____

Spouse/Guardian Information

His/Her Name: _____ Phone number: _____

Dental Plan Information- Dental Coverage? **YES / NO.** If yes, please fill out the information below.

Primary Dental Insurance Name: _____ Phone Number: _____

Policy Holder: _____ DOB: _____ Social Security #: _____

Relation: _____ Employer: _____ **Group #:** _____ **ID #:** _____

Claims Address: _____ City: _____ State: _____ Zip Code: _____

Secondary Dental Insurance Name: _____ Phone Number: _____

Policy Holder: _____ DOB: _____ Social Security #: _____

Relation: _____ Employer: _____ **Group #:** _____ **ID #:** _____

Claims Address: _____ City: _____ State: _____ Zip Code: _____

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 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 how your smiles 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 #: _____

Date of last exam: _____
Date of last cleaning: _____
Date if last X-Rays: _____

Would you like our office to request your X-Rays?
YES / NO
If '**NO**', we will need to take new X-Rays.