HEALTH HISTORY AND REGISTRATION FORM

MARTIN J. HOFF, M.D., D.D.S.

Welcome to our office. Please complete the following confidential information so we can best serve you.

PATIENT INFORMATION (Please print)

Today's Date ________________ Home Telephone ____________________ Work Telephone ______________________

Name ____ Employer ____________________________

Address ____ Work Address _________________________

City ___________________________ Zip Code _____________ City ________________________ Zip ________

Birthdate ______________________________ Age ____________ Position ____________________________________

Marital Status _________________________ Sex (please circle one) Male Female

Referring Dentist's Name ______________________________ Orthodontist's Name ______________________________

Physician's Name ____________________________________ Reason for todays visit _____________________________

IF THE PATIENT IS A CHILD:

Name of Parent or Guardian ____

Address of Parent (if different than above) ____

School ____ Grade ____________________________________

SPOUSE INFORMATION

Name ____ Home Ph # ______________________________

Address ____ Work Phone ____________________ ext ________

Employer ____ Cell Phone ______________________________

Emergency Contact name and number ____

Family Members who have been patients here ____

DENTAL INSURANCE INFORMATION:

Primary Insurance Carrier

Name of Insured ____________________________

Soc. Sec. Number ____________________________

Date of Birth ____________________________

Relationship to Patient ____________________________

Insurance Name ____________________________

Group # ____________________________

Employer ____________________________

Union or Local # ____________________________

Date employed ____________________________

Secondary Insurance Carrier

Name of Insured ____________________________

Soc. Sec. Number ____________________________

Date of Birth ____________________________

Relationship to Patient ____________________________

Insurance Name ____________________________

Group # ____________________________

Employer ____________________________

Union or Local # ____________________________

Date employed ____________________________

MEDICAL INSURANCE INFORMATION:

Insurance Plan Name: ______________________________________ Policy # ______________________________

Name of Insured: (if different than above) ____

Social Sec. Number __________-__________-__________ Group # ______________________________

Relationship to Patient: ____

I hereby authorize payment directly to the above named doctor, of the group insurance benefits otherwise payable to me, and authorize the release of any information relating to this claim.

Date ______________________________ **Signature** ______________________________________

HEALTH HISTORY

Patient's Name ______________________ Date ______________

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? .... Y N
2. Has there been any change in your general health in the past year? .... Y N
3. Date of last physical exam ______________
4. Are you now under a physician's care for a particular problem? .... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: .... Y N
____
____
6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? .... Y N
   - B. Congenital Heart Disease? .... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) .... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? .... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Psychiatric Treatment, or other Nervous Disorder? .... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? .... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? .... Y N
   - H. Kidney Disease? .... Y N
   - I. Diabetes? .... Y N
   - J. Thyroid Disease (Goiter)? .... Y N
   - K. Arthritis? .... Y N
   - L. Stomach Ulcers or Colitis? .... Y N
   - M. Glaucoma? .... Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? .... Y N
   - O. Radiation (X-ray) treatment for Cancer? .... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - Q. Sinus or Nasal problems? .... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? .... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? .... Y N
   - B. Anticoagulants (Blood Thinners)? .... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? .... Y N
   - E. Steroids (Cortisone, etc.)? .... Y N
   - F. Tranquilizers? .... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? .... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? .... Y N
   - I. Any regular prescription medicine, pills or drugs ...Y N
     If Yes, please list: ______________________________
   - J Herbal or Holistic remedies, Vitamins or over-the-counter medications? .... Y N
     If Yes, please list: ______________________________
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? .... Y N
   - B. Penicillin or other antibiotics? .... Y N
   - C. Sedatives, Barbiturates? .... Y N
   - D. Aspirin or Ibuprofen? .... Y N
   - E. Codeine or other pain killers? .... Y N
   - F. Latex or Rubber Products? .... Y N
   - G. Other allergies or reactions? Please, list .... Y N
     ____
10. Do you smoke or chew Tobacco? .... Y N
    How much per day? _________
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? .... Y N
12. Have you had any serious problems associated with any previous dental treatment? .... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? .... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .... Y N
15. Do you wish to talk to the doctor privately about anything? .... Y N
16. **FEMALES ONLY**
    - A. Are you Pregnant, or **is there any chance** you might be Pregnant? .... Y N
    - B. Are you nursing .... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.

Date ______________ Signature of Person Completing Health History ______________ Doctor's Initials ______________

Medical Update: I have read my Health History dated ______________ and confirm that it adequately states past and present conditions.

Date ______________ Exceptions or changes ______________ Patient's Signature ______________ Doctor's Initials ______________

Date ______________ Exceptions or changes ______________ Patient's Signature ______________ Doctor's Initials ______________