



Andrew Hoffman

DMD

ADULT REGISTRATION AND HEALTH HISTORY

We would like to welcome you to our office. Our goal is to make each visit pleasant and educational in order to maintain your optimal oral health. In order to serve you properly, it is necessary for us to obtain the following information and maintain its currency.

Today's Date ____/____/____

PATIENT INFORMATION

First Name _____ Last Name _____ M.I. ____ Preferred Name _____
 Sex: M F Marital Status: Single Married Partnered Separated Divorced Widowed
 DOB ____/____/____ Age ____ Soc. Sec. # _____
 Home Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____ Ext. _____
 Preferred Phone Number: Home Cell Work E-mail Address _____
 If Student, Name of School/College _____ City _____ State _____ PT FT
 Employer _____ Occupation _____ How long there? _____
 Employer's Address _____ City _____ State _____ Zip _____
 Other family members seen by us _____ Whom may we thank for referring you? _____

PERSON RESPONSIBLE FOR THIS ACCOUNT

Self (if self, skip this section) Spouse Parent Other _____
 First Name _____ Last Name _____ M.I. ____ DOB ____/____/____ Soc. Sec. # _____
 Home Address (if different from patient's) _____ City _____ State _____ Zip _____
 Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____ Ext. _____
 Preferred Phone Number: Home Cell Work E-mail Address _____
 Employer _____ Occupation _____ How long there? _____

SPOUSE/PARTNER INFORMATION (If different from above)

First Name _____ Last Name _____ M.I. ____ DOB ____/____/____ Soc. Sec. # _____
 Home Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____ Ext. _____
 Preferred Phone Number: Home Cell Work E-mail Address _____
 Employer _____ Occupation _____ How long there? _____

EMERGENCY CONTACT INFORMATION (Other than Spouse/Partner)

Name _____ Relationship to Patient _____
 Address _____ City _____ State _____ Zip _____
 Primary Phone (____) _____ Home Cell Work Alternative Phone (____) _____ Home Cell Work

DENTAL INSURANCE INFORMATION

Dental Coverage? Yes No If yes, complete the following:

Primary Insurance Company Name _____
 Insurance Company Address _____ City _____ State _____ Zip _____
 Insurance Company Phone Number (____) _____ ID# _____
 Group Name _____ Group# _____ Policy Holder's Name _____
 Relationship to Patient _____ DOB ____/____/____ Soc. Sec. # _____ Employer _____

Secondary Insurance Company Name (if applicable) _____
 Insurance Company Address _____ City _____ State _____ Zip _____
 Insurance Company Phone Number (____) _____ ID# _____
 Group Name _____ Group# _____ Policy Holder's Name _____
 Relationship to Patient _____ DOB ____/____/____ Soc. Sec. # _____ Employer _____

Are you allergic or have you had an adverse reaction to any of the following?

- | | | | | | |
|--------------------|--|----------------|--|--------------|--|
| Aspirin | <input type="radio"/> Yes <input type="radio"/> No | Jewelry/Metals | <input type="radio"/> Yes <input type="radio"/> No | Penicillin | <input type="radio"/> Yes <input type="radio"/> No |
| Latex | <input type="radio"/> Yes <input type="radio"/> No | Sulfa Drugs | <input type="radio"/> Yes <input type="radio"/> No | Tetracycline | <input type="radio"/> Yes <input type="radio"/> No |
| Dental Anesthetics | <input type="radio"/> Yes <input type="radio"/> No | Iodine | <input type="radio"/> Yes <input type="radio"/> No | Sedatives | <input type="radio"/> Yes <input type="radio"/> No |
| Codeine | <input type="radio"/> Yes <input type="radio"/> No | | | | |

Please list any other medications or antibiotics you are allergic to:

Please list any allergies other than drug allergies:

DENTAL HISTORY

Previous Dentist _____ City _____ State _____

Date of Last Visit ____/____/____ Date of Last X-rays ____/____/____

Why have you come to the dentist today? _____

Are you currently in pain? Y N For how long? _____

Do you require antibiotic premedication before dental treatment? Y N

- | | | | |
|--|---|--|---|
| Due to: <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Immunocompromised/
Immunosuppressed |
| <input type="checkbox"/> Previous Endocarditis | <input type="checkbox"/> Cardiac Transplant | <input type="checkbox"/> Kidney Disorder | |

Have you ever had a serious/difficult problem with any previous dental treatment? Y N

If yes, please explain: _____

Does dental treatment make you nervous? No Slightly Moderate Extremely

Your current dental health is: Excellent Good Fair Poor

How often do you brush your teeth? _____

What type of brush do you use? Manual Electric

What type of bristles are on your toothbrush? Soft Medium Hard

Do you floss? Y N If yes, how often? _____

How often do you usually get your teeth cleaned: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

Is your home water supply fluoridated? Y N

Have you ever been treated for periodontal (gum) disease? Y N

If yes, please explain: _____

Have you ever had orthodontic treatment? Y N

Do you still have wisdom teeth? Y N

Are you missing any teeth? Y N

If yes, have they been replaced by: Bridge: Year _____ Implant: Year _____ Partial Denture: Year _____ Full Denture: Year _____

Would you like whiter teeth (teeth whitening)? Y N

Are you happy with the way your smile looks? Y N

If not, what would you change? _____

Please indicate any of the following problems by checking off the corresponding box:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Food collection between teeth |
| <input type="checkbox"/> Red, swollen or bleeding gums | <input type="checkbox"/> Difficulty closing/opening jaw | <input type="checkbox"/> Broken filling |
| <input type="checkbox"/> Receding gums | <input type="checkbox"/> Jaw pain (joint, ear, side of face) | <input type="checkbox"/> Lip or cheek biting |
| <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Teeth clenching/grinding | <input type="checkbox"/> Loose teeth |
| <input type="checkbox"/> Burning tongue/lips | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Full/partial denture(s) |
| <input type="checkbox"/> Sores or growths in your mouth | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Night guard |
| <input type="checkbox"/> My teeth are sensitive to: | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Serious injury to mouth or head |
| <input type="checkbox"/> Hot <input type="checkbox"/> Cold <input type="checkbox"/> Sweets <input type="checkbox"/> Biting | <input type="checkbox"/> Toothache | <input type="checkbox"/> Other _____ |

Is there anything else you would like us to know about your dental health or previous dental treatment?

AUTHORIZATION AND RELEASE

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform Dr. Hoffman of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment. If Dr. Hoffman accepts my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Andrew Hoffman DMD of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

X Signature of Patient: _____ Date: ____ / ____ / ____

FOR OFFICIAL USE ONLY

Reviewed by: _____ Date: ____ / ____ / ____