Andrew Hoffman DMD

ADULT HEALTH HISTORY UPDATE

Today's Date ____/____/____

PATIENT INFORMATION

First Name _____ Last Name _____
Marital Status: ❍ Single ❍ Married ❍ Partnered ❍ Separated ❍ Divorced ❍ Widowed
DOB ____/____/____ Age _____
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 _____

EMERGENY CONTACT INFORMATION (Other than Spouse/Partner)

Name _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Primary 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 _____ 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 _____ DOB ____/____/____ Soc. Sec. # _____ Employer _____

MEDICAL HISTORY UPDATE

Are you currently under the care of a physician? ❍ Yes ❍ No Reason _____
Physician's Name _____ City _____ State _____ Phone # (_____) _____
Your current physical health is: ❍ Excellent ❍ Good ❍ Fair ❍ Poor
Has there been any change in your general health since your last visit? ❍ Yes ❍ No
If yes, please explain: _____
Please list any surgeries/hospitalizations since your last visit (include dates): _____
_____
Do you smoke or use tobacco in any form? ❍ Yes ❍ No Have you had any metal rods, pins, or implants? ❍ Yes ❍ No
Have you ever taken any bone density medication, such as Fosamax, or any other bisphosphonate? ❍ Yes ❍ No How long? _____

Women Only
Are you using a prescribed method of birth control? ❍ Y ❍ N Are you pregnant? ❍ Y ❍ N Week # _____ Are you nursing? ❍ Y ❍ N

Please complete the checklist if you have experienced any of the following diseases, conditions or procedures since your last visit:

AIDS /HIV Positive	❍ Yes ❍ No	Eating Disorder	❍ Yes ❍ No	Mental Health Disorders	❍ Yes ❍ No
Alcohol/Drug Abuse	❍ Yes ❍ No	Emphysema/COPD	❍ Yes ❍ No	Mitral Valve Prolapse	❍ Yes ❍ No
Anemia	❍ Yes ❍ No	Epilepsy/Seizures	❍ Yes ❍ No	Osteoporosis	❍ Yes ❍ No
Angina	❍ Yes ❍ No	Fainting Spells/Dizziness	❍ Yes ❍ No	Pacemaker	❍ Yes ❍ No
Arteriosclerosis	❍ Yes ❍ No	Frequent Headaches/Migraines	❍ Yes ❍ No	Parkinson's Disease	❍ Yes ❍ No
Arthritis	❍ Yes ❍ No	Gastrointestinal Disease	❍ Yes ❍ No	Persistent Swollen Glands in Neck	❍ Yes ❍ No
Artificial Heart Valve	❍ Yes ❍ No	G.E. Reflux/Persistent Heartburn	❍ Yes ❍ No	Rapid Weight Loss or Gain	❍ Yes ❍ No
Asthma	❍ Yes ❍ No	Glaucoma/Cataracts	❍ Yes ❍ No	Recurrent Infections	❍ Yes ❍ No
Autoimmune Disease	❍ Yes ❍ No	Hay Fever/Allergies	❍ Yes ❍ No	Specify: _____	
Bleed/Bruise Easily	❍ Yes ❍ No	Heart Attack	❍ Yes ❍ No	Renal Dialysis	❍ Yes ❍ No
Blood Transfusion	❍ Yes ❍ No	Heart Murmur	❍ Yes ❍ No	Rheumatic Fever	❍ Yes ❍ No
Date(s): _____		Hemophilia	❍ Yes ❍ No	Sexually Transmitted Disease	❍ Yes ❍ No
Bronchitis/Chronic Cough	❍ Yes ❍ No	Hepatitis Type_____	❍ Yes ❍ No	Shingles	❍ Yes ❍ No
Cancer/Chemotherapy/Radiation	❍ Yes ❍ No	High Blood Pressure	❍ Yes ❍ No	Shortness of Breath	❍ Yes ❍ No
Specify: _____		Irregular Heartbeat	❍ Yes ❍ No	Sickle Cell Disease/Traits	❍ Yes ❍ No
Cardiovascular Disease	❍ Yes ❍ No	Jaundice	❍ Yes ❍ No	Sinus Trouble	❍ Yes ❍ No
Chronic Pain	❍ Yes ❍ No	Joint Replacement	❍ Yes ❍ No	Stroke	❍ Yes ❍ No
Congestive Heart Failure	❍ Yes ❍ No	Kidney Disease	❍ Yes ❍ No	Thyroid Condition	❍ Yes ❍ No
Congenital Heart Defect	❍ Yes ❍ No	Liver Disease	❍ Yes ❍ No	Tuberculosis	❍ Yes ❍ No
Dementia/Alzheimer's Disease	❍ Yes ❍ No	Low Blood Pressure	❍ Yes ❍ No	Tumors/Growths	❍ Yes ❍ No
Diabetes	❍ Yes ❍ No	Lupus	❍ Yes ❍ No	Ulcers	❍ Yes ❍ No

Please list any other serious medical condition(s) since your last visit:

What pharmacy do you use most regularly? _____

Location _____ Phone # (_____) _____

Medications and Drug Allergies

Are you taking any prescription/over-the-counter medications? ❍ Y ❍ N

Please complete the following table regarding your current prescription and non-prescription medications:

Medication	Dosage and Frequency	Purpose

Please complete the checklist if you are allergic or have had an adverse reaction to any of the following since your last visit:

Aspirin	❍ Yes ❍ No	Jewelry/Metals	❍ Yes ❍ No	Penicillin	❍ Yes ❍ No
Latex	❍ Yes ❍ No	Sulfa Drugs	❍ Yes ❍ No	Tetracycline	❍ Yes ❍ No
Dental Anesthetics	❍ Yes ❍ No	Iodine	❍ Yes ❍ No	Sedatives	❍ Yes ❍ No
Codeine	❍ Yes ❍ No				

Please list any other medications or antibiotics you are allergic to since your last visit:

Please list any allergies other than drug allergies since your last visit:

DENTAL HISTORY UPDATE

Why have you come to the dentist today? _____

Do you require antibiotic premedication before dental treatment? ❍ Y ❍ N

Due to:
- ❑ Artificial Heart Valve
- ❑ Congenital Heart Disease
- ❑ Joint Replacement
- ❑ Immunocompromised/ Immunosuppressed
- ❑ Previous Endocarditis
- ❑ Cardiac Transplant
- ❑ Kidney Disorder

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? _____
Would you like whiter teeth (teeth whitening)? ❍ Y ❍ N
Are you happy with the way your smile looks? ❍ Y ❍ N
If yes, what would you change? _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

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: ____ /____/ ____

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Reviewed by: _____ Date: ____ /____/ ____

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