Scott A. Hoffman, D.D.S.
General and Preventive Dentistry
A Professional Corporation

Please complete the following Confidential Information

PATIENT INFORMATION

E-Mail _____ Cell Phone _____

Date _____ Home Telephone _____ Office Telephone _____

Name _____ Employer _____

Address _____ Business Address _____

City _____ Zip Code _____ City _____

Birthdate _____ Age _____ Position _____

Marital Status _____ Social Security # _____

IF THE PATIENT IS A CHILD

Name of Parent or Guardian _____

School _____ Grade _____

SPOUSE INFORMATION

Name _____ City _____

Employer _____ Business Phone _____ Ext. _____

Business Address _____ Position _____

Whom may we thank for referring you? _____

GENERAL INFORMATION

Convenient appointment time _____ Person responsible for account _____

Are you available for appointments on short notice ____ Relationship to patient _____

Person to contact for emergency _____ Driver's License # _____
(not at same address)

Relationship to patient _____ Bank _____ Branch _____

Their telephone _____

IF YOU HAVE DENTAL INSURANCE, PLEASE FILL IN THE FOLLOWING:

PRIMARY CARRIER	SECONDARY CARRIER
Name of insured _____	Name of insured _____
Social Security # _____	Social Security # _____
Insurance carrier name _____	Insurance carrier name _____
Birthdate _____	Birthdate _____
Employer _____	Employer _____
Union or Local # _____	Union or Local # _____
AID or Group # _____	AID or Group # _____
Date employed _____	Date employed _____

PATIENT'S MEDICAL HISTORY

Please answer EACH question

1. Are you in good health? ❑ Yes ❑ No
2. Date of last physical examination? _____
3. Have you ever been hospitalized? ❑ Yes ❑ No
4. Are you taking any drugs or medications, ❑ Yes ❑ No
   If so, What? _____
5. Are you sensitive or allergic to any drugs? ❑ Yes ❑ No
   If so, which drugs?
6. Do you take any recreational drugs? ❑ Yes ❑ No
7. Do you take any herbal supplements? ❑ Yes ❑ No
   If yes, what? _____
8. Do you take Ephedrine/ Ephedra? ❑ Yes ❑ No
9. Have you ever taken Fen Phen ❑ Yes ❑ No
10. Are you taking any over the counter medications? ❑ Yes ❑ No
    If so, What? _____
11. Do you wear a cardiac pacemaker? ❑ Yes ❑ No
12. Have you ever had heart surgery? ❑ Yes ❑ No
13. Are you now under the care of an M.D.? ❑ Yes ❑ No
14. Have you had any serious illness? ❑ Yes ❑ No
15. Blood pressure, if known _____
16. Have you ever been exposed to the Aids Virus? ❑ Yes ❑ No
17. Are you on blood thinners ? ❑ Yes ❑ No

Physician's name _____

Address _____ Phone _____

18. Do you have, or have you had any of the following:

Y	N		Y	N		Y	N	
❑	❑	Rheumatic Fever	❑	❑	Heart Ailments	❑	❑	Fainting spells or seizures
❑	❑	Blood Diseases	❑	❑	Heart Murmur	❑	❑	Sinus trouble
❑	❑	Hepatitis, jaundice or liver disease	❑	❑	High Blood Pressure	❑	❑	Rheumatism or arthritis
❑	❑	Respiratory Disease	❑	❑	Kidney Disease	❑	❑	Head Injuries
❑	❑	Tuberculosis	❑	❑	Tumors or Growths	❑	❑	Stomach Ulcers
❑	❑	Nervous Disorders	❑	❑	Radiation treatment of any kind	❑	❑	Venereal Diseases
❑	❑	Diabetes	❑	❑	Allergies	❑	❑	Epilepsy
❑	❑	Excessive Bleeding	❑	❑	Asthma or hay fever	❑	❑	Stroke
❑	❑	Mitral Valve Prolapse	❑	❑	Latex Allergy	❑	❑	Artificial Joints
						❑	❑	Sexual transmitted diseases

FOR WOMEN ONLY

Are you pregnant? ❑ Yes ❑ No If yes, what month? _____

Obstetrician's name _____

Address _____ Phone _____

DENTAL HISTORY

1. How long since you've been to a dentist? _____
2. How often do you floss your teeth? _____
3. How often do you brush your teeth? _____
4. Have you ever been treated for periodontal Diseases? ❑ Y ❑ N
5. Have you ever had any complications from an extraction? ❑ Y ❑ N
   Explain: _____
6. Have you ever had a popping or clicking near your ear when chewing? ❑ Y ❑ N
7. Do you grind your teeth? ❑ Y ❑ N
8. Do your gums bleed when you brush? ❑ Y ❑ N
9. Do you have sores, blisters or swelling on your gums, lips or cheeks? ❑ Y ❑ N
10. Have you ever had orthodontic treatment? ❑ Y ❑ N
11. When was your last set of full mouth X-rays taken?
    Date: _____ Where? _____

REMARKS

IS THERE ANY ADDITIONAL MEDICAL OR DENTAL INFORMATION WE MAY NEED TO KNOW BEFORE BEGINNING TREATMENT? _____

CONSENT

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient)_____ and further authorize and consent that Doctor choose to employ such assistance as he deems fit. I understand that responsibility for payment for Dental Services provided in this office for my dependents or myself is mine, due and payable at the time service are rendered. Signature_____ Date_____

Relationship to Patient_____

HEALTH HISTORY UPDATE

Date _____

Changes _____

Signature _____

Date _____

Changes _____

Signature _____