PATIENT REGISTRATION & MEDICAL/DENTAL HISTORY

Raymond C Hahn DDS, PC

PATIENT INFORMATION

PATIENT'S NAME Last _____ First_____ Middle Initial _____
Name you prefer to be called _____ Today's Date _____
Soc. Sec. # _____ SEX: M F Birthdate _____
If Minor, Parent's or Guardian's Name _____
Reason for this Visit _____
Who May We Thank for Referring You to our Office? _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First_____ Middle Initial _____
Relationship to Patient _____ Soc. Sec. # _____
SEX: M F Marital Status _____ Birthdate _____
ADDRESS Street _____ Apt # _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Work Phone _____ Email _____
Driver's License # _____ State Issued _____
Employer _____ Occupation _____ Years employed ____

DENTAL INSURANCE INFORMATION

Insured's Name _____
Insured's Birthdate _____ Soc. Sec. # _____
Insurance Company _____
Ins. Co. Address _____
Ins. Co. Phone _____ Insured's Employer _____
Group # _____ Subscriber # _____

EMERGENCY CONTACT INFORMATION

Name _____Relationship_____
Address _____
Home Phone _____ Cell Phone _____
Work Phone _____ Email _____

It is required that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to fill out this questionnaire.

DENTAL HISTORY

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Approx date of last visit_____ Yes No
Date of last full mouth x-rays (14 small films or panoramic) _____
Do you think you have active decay or gum disease? _____ Yes No
Have you had any periodontal (gum) treatments? Describe _____ Yes No
Do you floss your teeth on a routine basis? How often? _____ Yes No
Do your gums ever bleed or feel tender or irritated? Describe_____ Yes No
Does food catch between your teeth? _____ Yes No
Are your teeth sensitive to hot, cold, sweats or chewing? Describe _____ Yes No
Do you like your smile? Why or why not? _____ Yes No
Do you expect to keep all of your teeth for a lifetime? _____ Yes No
Do you ever hear clicking or popping, or feel discomfort in the jaw joint? _____ Yes No
Do you clench or grind your teeth? Describe _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Are you apprehensive about dental treatment? If yes, why? _____ Yes No
Do you smoke or chew tobacco? Describe frequency _____ Yes No
Name, address and phone of previous dentist _____

MEDICAL HISTORY

Please Circle

Are you under a physician's care now? Why? _____ Yes No

Physician's Name_____ Phone _____ _____

Have you ever been hospitalized or had a major operation? Discuss_____ Yes No

Have you ever had a serious injury to your head or neck? Discuss_____ Yes No

Are you taking any medications, pills or drugs? Please list type & purpose _____ Yes No

_____

Are you on a special diet? Discuss_____ Yes No

Are you allergic to any medications or substances? Please check box below_____ Yes No

☐ Aspirin ☐ Penicillin ☐ Erythromycin ☐ Codeine ☐ Nitrous Oxide ☐ Local Anesthetic

☐ Latex ☐ Other _____

Are you taking, or have you taken bisphosphonate drugs? Please check box below_____ Yes No

☐ Fosamax ☐ Boniva ☐ Actonel ☐ Skelid ☐ Didronel ☐ IV Aredia ☐ IV Zometa

Women (Please check): ☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Do you now have or have you ever had any of the following? Please check appropriate boxes.
**If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.*

	Yes	No
Heart Disease/Surgery*	_	_
Heart Murmur*	_	_
Mitral Valve Prolapse*	_	_
Rheumatic Fever*	_	_
Artificial Heart Valve*	_	_
Artificial Joint*	_	_
Ever taken Fen-Phen?*	_	_
Heart Pacemaker	_	_
Irregular Heart Beat	_	_
Angina/Chest Pain	_	_
Heart Attack/Failure	_	_
Congenital Heart Disorder	_	_
High Blood Pressure	_	_
Bacterial Endocarditis	_	_
Blood Disease	_	_
Anemia	_	_
Excessive Bleeding	_	_
Sickle Cell Disease	_	_
Hemophilia	_	_
Leukemia	_	_
Recent Blood Transfusion	_	_
Swelling of Limbs	_	_
Lung Disease	_	_

	Yes	No
Shortness of Breath	_	_
Frequent Cough	_	_
Hay Fever	_	_
Sinus Trouble	_	_
Asthma	_	_
Bloody Sputum	_	_
Emphysema	_	_
Tuberculosis	_	_
Cancer	_	_
Radiation Treatments	_	_
Chemotherapy	_	_
Stomach/Intestinal Disease	_	_
Ulcers/Colitis	_	_
Rapid Weight Gain/Loss	_	_
Frequent Diarrhea	_	_
Diabetes	_	_
Excessive Thirst	_	_
Hypoglycemia	_	_
Liver Disease	_	_
Hepatitis A (Infectious)	_	_
Hepatitis B or C	_	_
Night Sweats	_	_
Yellow Jaundice	_	_

	Yes	No
Kidney Problems	_	_
Renal Dialysis	_	_
Thyroid Disease	_	_
Parathyroid Disease	_	_
Arthritis	_	_
Venereal Disease	_	_
HIV/AIDS	_	_
Genital Herpes	_	_
Oral Herpes/Fever Blisters	_	_
Drug Dependency	_	_
Alcoholism	_	_
Tattoos/Body Piercing	_	_
Stroke	_	_
Epilepsy/Seizures	_	_
Fainting or Dizziness	_	_
Glaucoma	_	_
Psychiatric Care	_	_
Nervousness/Anxiety	_	_
Alzheimer's Disease	_	_
Migraines/Headaches	_	_
Auto-immune Disease	_	_
Need Premedication?	_	_

Have you ever had any other serious illness not checked above? If so, Describe _____

_____

To the best of my knowledge. all the preceding answers are correct. If there are any changes to my health status or my medications, I shall inform the dentist and staff at the next appointment.

PATIENT SIGNATURE (PARENT OR GUARDIAN)

x _____ Date _____

Reviewed By Doctor (Signature) _____ Date _____

MEDICAL UPDATES

Date	Changes		Patient Signature	Reviewed By
_____	_____	None ☐	_____	Dr. _____
_____	_____	None ☐	_____	Dr. _____
_____	_____	None ☐	_____	Dr. _____
_____	_____	None ☐	_____	Dr. _____
_____	_____	None ☐	_____	Dr. _____