CONFIDENTIAL

Patient Information

PETER HOFFMANN DMD • PC
HEALTHY TEETH • HAPPY SMILES

Date_____
Patient ID #_____
SS#/SIN_____

Welcome!

Thank you for selecting our dental health care team! We will strive to provide you with the best possible dental care. To help us meet all your healthcare needs, fill out this form completely. If you have any questions, please ask us—we will be happy to help.

Personal Information

Name_____ Birthdate_____ Home Phone_____
Social Security #_____ Cell Phone_____
Email Address_____
Address_____ City_____ State_____ Zip_____
Are you: ☐ Minor ☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated
If you are a student, name of school/college_____ ☐ Full Time ☐ Part Time
Address_____ City_____ State_____ Zip_____
Patient or parent's employer_____ Work Phone_____
Address_____ City_____ State_____ Zip_____
Spouse or Parent's name_____ Employer_____ Phone_____
Whom may we thank for referring you?_____
Person to contact in case of an emergency_____ Phone_____

Responsible Party

Name of person responsible for this account_____
Relationship to patient_____ Birthdate_____ Home Phone_____
Email Address_____ Cell Phone_____
Employer_____ Work Phone_____
Address_____ City_____ State_____ Zip_____
Driver's License #_____ Social Security #_____
Financial Institution_____
Is this person currently a patient in our office? ☐ Yes ☐ No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment is appreciated.

☐ **Cash** ☐ **Personal Check** **Credit Card**: ☐ Visa ☐ MasterCard
☐ I wish to discuss the office's payment policy

Insurance Information

Name of Insured_____ Relationship to Patient_____
Birthdate_____ Social Security #_____ Date Employed_____
Name of Employer_____ Union/Local #_____ Work Phone_____
Address of Employer_____ City_____ State_____ Zip_____
Insurance Company_____ Group #_____ Policy/ID #_____
Ins. Co. Address_____ City_____ State_____ Zip_____
What is your deductible?_____ How much have you used?_____ Max. annual benefit?_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured_____ Relationship to Patient_____
Name of Employer_____ Union/Local #_____ Work Phone_____
Address of Employer_____ City_____ State_____ Zip_____
Insurance Company_____ Group #_____ Policy/ID #_____
Ins. Co. Address_____ City_____ State_____ Zip_____
What is your deductible?_____ How much have you used?_____ Max. annual benefit?_____

Patient Medical History

Your Physician:_____ **Office Phone:**_____ **Date of Last Exam:**_____

Are you under medical treatment now?	☐ Yes ☐ No	If yes, please explain:_____
Have you ever been hospitalized for any surgical operation or serious illness in the last 5 years?	☐ Yes ☐ No	If yes, please explain:_____
Are you taking any medication(s), including any non-prescription medicine?	☐ Yes ☐ No	If Yes, please list:_____
Have you ever taken Phen-Fen/Redux?	☐ Yes ☐ No	
Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing hisphosphonates?	☐ Yes ☐ No	
Have you ever taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐ Yes ☐ No	
Do you use tobacco?	☐ Yes ☐ No	
Do you use controlled substances?	☐ Yes ☐ No	
Are you wearing contact lenses?	☐ Yes ☐ No	

Are you allergic or have you had any reactions to any of the following:

Aspirin	☐ Yes ☐ No	Iodine	☐ Yes ☐ No	Latex	☐ Yes ☐ No
Sulfa drugs	☐ Yes ☐ No	Barbiturates	☐ Yes ☐ No	Sedatives	☐ Yes ☐ No
Metals	☐ Yes ☐ No	Local Anesthetics e.g. Novocain	☐ Yes ☐ No	Penicillin/Antibiotics	☐ Yes ☐ No
Other:	☐ Yes ☐ No	Please List:_____			

Other:

Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ☐ Yes ☐ No

Women are you:

Pregnant or think you may be pregnant?	☐ Yes ☐ No	Nursing?	☐ Yes ☐ No
Taking oral contraceptives?	☐ Yes ☐ No		

Do you have any of the following?

High Blood Pressure	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No
Swollen Ankles	☐ Yes ☐ No
Fainting/Seizures	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No
Epilepsy/Convulsions	☐ Yes ☐ No
Leukemia	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No
AIDS/HIV Positive	☐ Yes ☐ No
Thyroid Problem	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No
Cardiac Pacemaker	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No
Angina	☐ Yes ☐ No
Frequently Tired	☐ Yes ☐ No
Anemia	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No

Cancer	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No
Joint Replacement/Implant	☐ Yes ☐ No
Hepatitis/Jaundice	☐ Yes ☐ No
Sexually Transmitted Disease	☐ Yes ☐ No
Stomach Troubles/Ulcers	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No
Easily Winded	☐ Yes ☐ No
Stroke	☐ Yes ☐ No
Hay Fever/Allergies	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No
Radiation Therapy	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No
Recent Weight Loss	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No
Heart Trouble	☐ Yes ☐ No
Respiratory Problems	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No
Other	☐ Yes ☐ No

If yes, please explain:_____

Patient Dental History

Previous Dentist & Location:_____ **Date of Last Exam:**_____

Do your gums bleed while brushing or flossing?	☐ Yes ☐ No
Are your teeth sensitive to hot /cold liquids or foods?	☐ Yes ☐ No
Do you feel pain in any of your teeth?	☐ Yes ☐ No
Do you have any sores or lumps in or near your mouth?	☐ Yes ☐ No
Have you had any head, neck or jaw injuries?	☐ Yes ☐ No
Have you ever experienced any of the following problems in your jaw?	
Clicking	☐ Yes ☐ No
Pain (joint, ear, or side of face)	☐ Yes ☐ No
Difficulty in opening or closing	☐ Yes ☐ No
Difficulty in chewing	☐ Yes ☐ No
Do you have frequent headaches?	☐ Yes ☐ No

Do you clench or grind your teeth?	☐ Yes ☐ No
Do you bite you lips or cheeks frequently?	☐ Yes ☐ No
Have you had difficult extractions in the past?	☐ Yes ☐ No
Have you had prolonged bleeding after an extraction?	☐ Yes ☐ No
Have you had any orthodontic treatment?	☐ Yes ☐ No
Do you wear dentures or partials?	☐ Yes ☐ No
If yes, date of placement:_____	
Have you ever receive oral hygiene instructions for your teeth and gums?	☐ Yes ☐ No
Do you like your smile?	☐ Yes ☐ No

Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Date_____

Signature of Patient (or parent of patient if patient is a minor)

Doctor's Comments:_____

_____

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Doctors Signature_____ Date_____