HEALTH HISTORY/REGISTRATION

SUSAN ION HOGAN, DDS, PA

To whom may we thank for referring you to our office____

Have we seen anyone in your family, if so, who?____

Patient's Name: ____**Date of Birth:** ______________________________

Mailing Address: ____

City/State: ____**Zip:** ______________________

Home Phone: _______________________ **Work Phone:** _____________________**Cell:** _________________________

SS#: ___________________________________**Email:** ____

Occupation: _________________________________**Employer:** ____

Spouse/Parent's Name: ____

Person Financially Responsible: ____

Person to Contact in Case of Emergency: ____

Phone #: ____________________________________**Relation:** ____

Dental Insurance Company: ________________________________ **Policy/Group#:** ____________________________

Subscriber's Name: ___________________________________ **Subscriber's Date of Birth:** _______________________

Subscriber's Relation to You: _____________________ **Subscriber's Employer**__________________________________

SS#/ Subscriber ID #: ___________________________________ **Ins. Phone #:** ___________________________________

MAIN DENTAL CONCERNS:____

Last Dental visit: _______________________**Reason:** ____

When was your last dental cleaning?: ______________________ **Last X-rays?:**_________________________________

Are you aware of grinding or clenching?: __________________ **Do you currently wear a Night Guard?** ___________

Do you have pain in your jaw, neck, or face?: ____

Is there anything else you would like us to know about your dental health? __________________________________

____

GENERAL PHYSICIAN__________________________________ PHYSICIAN'S PHONE #:______________________________

DO YOU NEED TO BE PREMEDICATED DUE TO A MEDICAL CONDITION FOR YOUR DENTAL APPTS.? _______________FOR WHAT REASON____

WHAT PREMEDICATION DO YOU TAKE?: ____

HAVE YOU BEEN HOSPITALIZED IN THE LAST 2 YRS.?______IF SO, PLEASE EXPLAIN______________________________

CHECK OR CIRCLE ALL THAT APPLY:

- ☐ HIGH BLOOD PRESSURE
- ☐ HEART SURGERY
- ☐ ANGINA
  - Do you take Nitroglycerin? ______
- ☐ PACEMAKER
- ☐ IRREGULAR HEART BEAT
- ☐ STROKE Date:______________
- ☐ HEART ATTACK
- ☐ PROSTHETIC HEART VALVE
- ☐ MITRAL VALVE PROLAPSE
- ☐ ARTIFICIAL JOINT
  - ➢ HIP / KNEE / OTHER
  - Date: ____________________
- ☐ DIABETES
  - ➢ TYPE I / TYPE II (circle)
  - Do you take Insulin? __________
- ☐ BLOOD DISEASE
- ☐ BLOOD TRANSFUSION
- ☐ HEMOPHILIA
- ☐ EPILEPSY
- ☐ GLAUCOMA
- ☐ TUMOR HISTORY
- ☐ CANCER / RADIATION
  - Date:_________________
- ☐ CHEMOTHERAPY
- ☐ LIVER/KIDNEY DISEASE
- ☐ OSTEOPOROSIS
- ☐ APHTHOUS ULCERS
- ☐ LUPUS
- ☐ ARTHRITIS
- ☐ COSMETIC SURGERY
- ☐ SMOKER
- ☐ HEPATITIS A / B / C (please circle)
- ☐ AIDS / HIV
- ☐ HIGH CHOLESTEROL
- ☐ TUBERCULOSIS
- ☐ EMPHYSEMA LUNG DISEASE
- ☐ ULCERS
- ☐ COLD SORES
- ☐ ASTHMA / DIFFICULTY BREATHING
- ☐ RECENT WEIGHT CHANGE
- ☐ ANOREXIA/BULIMIA
- ☐ ANEMIA
- ☐ SINUS TROUBLE
- ☐ FREQUENT HEADACHES
- ☐ STENT
- ☐ HORMONE REPLACEMENT
- ☐ SLEEP APNEA
- ☐ MENTAL ILLNESS/ANXIETY/ DEPRESSION/ explain____

FOR WOMEN:	**ALLERGIES:**
Are you pregnant? ☐ Yes ☐ No	☐ PENICILLIN ☐ ASPIRIN ☐ CODEINE
Due Date: _________________	☐ LATEX ☐ SULFA ☐ EPINEPHRINE
Nursing? ☐ Yes ☐ No	☐ DENTAL ANESTHETICS ☐ METALS
Are you taking birth control pills? ☐ Yes ☐ No	☐ OTHER:__________________________________

OTHER MEDICAL CONDITIONS:____

DO YOU TAKE ANY KIND OF BLOOD THINNER MEDS?: _______IF SO, WHAT?: ____________________________________

DO YOU TAKE (or have you taken) BISPHOSPHONATE MEDS.?(for bone strength): ___________________________________

IF SO, WHAT?: ___________________________WHEN?: _____________________ FOR HOW LONG?: ______________________

HAVE YOU TAKEN ANY STEROID MEDS IN THE LAST 2 YEARS?_________WHAT?________________________________

HOW LONG?___________________________

LIST CURRENT MEDICATIONS: ____

I the undersigned consent to examination and treatment agreed to be necessary. I realize the risks involved. I agree to assume responsibility for fees associated with these procedures.

____ ________________________

PATIENT/GUARDIAN'S SIGNATURE **DATE**