

Lee S. Hauer, D.D.S
Periodontic & Implant Dentistry

Patient Name _____ Date _____

Street _____ City _____ Zip _____

DOB _____ SS# _____ Referred By _____

Home # _____ Cell# _____ Work# _____

E-Mail _____ Employer _____

Emergency Contact _____ Contact# _____

Dental Insurance _____ Subscriber's Name _____

Subscriber's Employer _____ DOB _____ SS# _____

Physician's Name and # _____ Last Physical Exam _____

Are you under a Physician's care now? Yes ___ No ___ If Yes, Why _____

Are you taking any prescription or over the counter medications? Please list them below.

Are you taking a blood thinner or Aspirin Yes ___ No ___ If yes, please list medications

Are you taking or have ever taken a bisphosphonate like Fosamax or Actonel? Yes ___ No ___

Have you ever had any serious illnesses or surgeries? Yes ___ No ___

If Yes, What type and when _____

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Are you allergic to or have had any reaction to? Check any that apply.

<input type="checkbox"/> Local Anesthetics	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin or other antibiotics
<input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> Iodine	<input type="checkbox"/> Latex
<input type="checkbox"/> Codeine/Narcotics	<input type="checkbox"/> Any metals	<input type="checkbox"/> other _____

Have you had any of the following? Please check any that apply.

<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Anemia
<input type="checkbox"/> Congenital heart defect	<input type="checkbox"/> Hepatitis/liver disease	<input type="checkbox"/> Cancer/chemo or radiation
<input type="checkbox"/> Heart valve replacement	<input type="checkbox"/> Hip or Knee replacement	<input type="checkbox"/> Treatment
<input type="checkbox"/> Stroke or Heart Attack	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Sinus trouble
<input type="checkbox"/> AIDS or HIV infection	<input type="checkbox"/> High or Low blood pressure	<input type="checkbox"/> Gastrointestinal disease
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Herpes
<input type="checkbox"/> Heart Murmur/MVP	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Dry mouth
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Other _____

Do your gums bleed when you brush or floss? Yes _____ No _____

Have you had any periodontal (gum) treatments? Yes _____ No _____

Have you ever had orthodontic (braces) treatment? Yes _____ No _____

Do you have any clicking, popping or discomfort in the jaw? Yes _____ No _____

Do you grind your teeth? Yes _____ No _____

Had any injury to your face? Yes _____ No _____

Do you wear dentures or partials? Yes _____ No _____

Do you use tobacco: cigarettes, cigars, pipes or chewing tobacco? Yes _____ No _____

Date of your last dental exam _____ Date of last dental cleaning _____

Reason for your visit today _____

I understand that it is my responsibility to know the benefits, limitations and exclusions of my dental insurance. The information given is accurate and correct to the best of my knowledge. I understand the uninsured difference is my financial responsibility and will be paid at the time service is rendered, unless other financial arrangements have been made.

Patient/Parent Signature _____ Date _____

Reviewed By _____ Updated on _____