Lee S. Hauer, D.D.S.
Specializing in Periodontics and Dental Implants
4350 Sheridan Street, Suite 201D, Hollywood, FL 33021

PERSONAL INFORMATION:

Name: _____ Date: _____

Address: _____
Street City State Zip

Home Phone: _____ Birth Date: _____

Cell Phone: _____ Soc.Sec.#: _____

Work Phone: _____ Employer: _____

Email: _____ Referred by: _____

Emergency Contact: _____ Phone: _____

DENTAL INSURANCE: If you have insurance through Delta Dental or through Memorial Hospital, we will be happy to accept assignment of benefits, meaning we will wait for your insurance to pay us and we will ask that you pay only your estimated co-pay at the time of treatment. If you have insurance through any other carriers, we will ask that you pay for your services in full at the time of treatment. We will be happy to file your insurance claims for you and ask that your insurance carrier send payment directly to you. If you have questions about your insurance benefits, we will be happy to work with you and your insurance company to answer your questions.

Carrier Name: _____ Phone: _____

Subscriber Name: _____ Subscriber ID: _____

Subscriber Birth Date: _____ Group Name/Number: _____

HEALTH HISTORY:

Physician's Name: _____ Phone: _____

Are you currently under a physician's care? ☐ YES ☐ NO Last Exam: _____

Please explain if YES: _____

Are you currently taking any medications? ☐ YES ☐ NO If YES, please list below:

_____

Are you taking a blood thinner or aspirin? ☐ YES ☐ NO If YES, please list below:

_____

Are you or have you ever taken a bisphosphonate like Fosomax or Actonel? ☐ YES ☐ NO

Have you ever had a serious illness or surgery? ☐ YES ☐ NO Please list/explain below:

_____

Are you allergic to or have you had a reaction to any of the following? Check all that apply.

	Local Anesthetics		Aspirin		Penicillin
	Sulfa Drugs		Iodine		Latex
	Codeine/Narcotics		Any Metals		Other

Do you have or have you had any of the following conditions? Check all that apply.

	Rheumatic Fever		Blood Transfusion		Kidney Disease
	Congenital Heart Defect		Hepatitis/Liver Disease		Anemia
	Heart Valve Replacement		Hip/Knee Replacement		Cancer/Chemo/Radiation
	Heart Attack/Stroke		Diabetes		Sinus Problems
	AIDS or HIV Infection		High Blood Pressure		Gastrointestinal Disease
	Hemophilia		Low Blood Pressure		Herpes
	Heart Murmur/MVP		Tuberculosis (TB)		Dry Mouth
	Thyroid Problems		Osteoporosis		Other

Are there any conditions, not listed above that we should be made aware of? _____

_____

Do your gums bleed when you brush or floss? ☐ YES ☐ NO

Have you had periodontal (gum) treatments in the past? ☐ 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

Have you had an injury to the 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 last dental exam: _____ Last cleaning: _____

Reason for today's visit? _____

The above information given is accurate and correct to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

Reviewed by: _____ Updated On: _____