Patient Number_____

MEDICAL & DENTAL HISTORY *CONFIDENTIAL*

Name_____ **Date of Birth**_____

Address_____ **City**_____ **State**___ **Zip**_____

Home Phone( )_____ **Business Phone( )**_____ **Cell/Pager( )**_____

E-Mail Address_____ **Best Daytime Contact** ☐**Home** ☐**Business** ☐**Cell/Pager**

Who is financially responsible for this account?_____

Your Employer_____ **Your Occupation**_____

Your Social Security Number_____/_____/_____

Do you have any insurance that may cover your treatment? ☐**Yes** ☐**No**

Insured person_____ **Relationship to Patient**_____

Insured's Date of Birth_____ **Carrier**_____ **Policy Number**_____

Spouse's Name_____ **Spouse's Occupation**_____

Spouse's Employer_____ **Spouse's Social Security No.**____/_____/_____

Additional Insurance Coverage? ☐ **Yes** ☐**No** **Carrier**_____ **Policy #**_____

Whom may we thank for referring you to our office?_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM AND ☒ ANY OF THE FOLLOWING CONDITIONS THAT CURRENTLY OR IN THE PAST APPLY TO YOU. IF "OTHER" PLEASE EXPLAIN ON BACK SIDE OF PAGE.

EYES
☐ Glaucoma ☐ Loss of Vision ☐ Other
☐ Contact Lenses ☐ Surgery

EARS
☐ Loss of hearing ☐ Ringing
☐ Surgery ☐ Other

NOSE
☐ Sinus Infections ☐ Excessive Discharge ☐ Other
☐ Nosebleeds ☐ Surgery

THROAT
☐ Laryngitis ☐ Sore ☐ Surgery
☐ Hoarseness ☐ Strep Throat ☐ Radiation Therapy
☐ Difficulty Swallowing ☐ Lumps ☐ Other

MOUTH
☐ Sores or Lumps ☐ Gumboils ☐ Sore Gums
☐ Bleeding Gums ☐ Lip Sores ☐ Implants
☐ Broken Jaw ☐ Clicking Jaw ☐ Popping Jaw
☐ Biting Lips ☐ Biting Cheeks ☐ Tartar
☐ Trench Mouth ☐ Unpleasant Taste ☐ Grafts/GTR
☐ Joint Pain ☐ Difficulty Chewing ☐ Scaling/Root Planing
☐ Smoke/Chew Tobacco ☐ Periodontal Surgery
☐ Difficulty Opening/Closing Jaw ☐ Other

TEETH
☐ Loose ☐ Sensitive to Hot ☐ Sensitive to Cold
☐ Sensitive to Sweet ☐ Sensitive to Sour ☐ Wedging of Food
☐ Grind/Clench ☐ Pain/Ache ☐ Sensitive to Pressure
☐ Chipped or Broken ☐ Braces ☐ Other

BONES/MUSCLES
☐ Breaks ☐ Stiffness ☐ Arthritis
☐ Artificial Joints or Implants ☐ Gout ☐ Other
☐ Head, Neck of Jaw Injuries

SKIN/BREAST
☐ Cancer ☐ Surgery ☐ Other
☐ Acne ☐ Radiation Treatment

CARDIOVASCULAR SYSTEM
☐ Attack ☐ Angina ☐ Chest Pain
☐ Surgery ☐ High Cholesterol ☐ High Blood Pressure
☐ Mitral Valve Prolapse ☐ Rheumatic Fever ☐ Low Blood Pressure
☐ Rheumatic Heart Disease ☐ Heart Murmur ☐ Stroke
☐ Valve Replacement ☐ Irregular Breathing ☐ Other
☐ Swelling of Feet or Ankles ☐ Pacemaker/Defibrillator

RESPIRATORY
☐ Tuberculosis ☐ Cough up Blood ☐ Lingering Cough ☐ Other
☐ Asthma ☐ Cystic Fibrosis ☐ Irregular Breathing ☐ Emphysema
☐ Smoke a Pipe ☐ Smoke Cigars ☐ Smoke Cigarettes ☐ Surgery
For How long have you smoked?_____
How many packs per day?_____
Would you like to quit?_____

BLOOD
☐ Hemophilia ☐ Leukemia ☐ Sickle Cell Anemia
☐ Pernicious Anemia ☐ Lymph Node Problems ☐ Anemia
☐ Bone Marrow Transplants ☐ Blood Transfusion ☐ Other
☐ Plasma Transfusion ☐ Transfusion of other blood products
☐ Other Clotting Disorders ☐ Lymphoma

IMMUNE SYSTEM
☐ Rheumatoid Arthritis ☐ Sjorgens Syndrome ☐ Lupus
☐ Hypersensitivity Reactions ☐ HIV ☐ AIDS
☐ Other Autoimmune Disorders ☐ Chemotherapy ☐ Other

ENDOCRINE
☐ Diabetes ☐ Excessive Thirst ☐ Under Weight
☐ Frequent Urination ☐ Thyroid Disorder/Removal ☐ Other
☐ High Loss of Weight ☐ Hormone Replacement Therapy

GASTRO-INTESTINAL

☐ Jaundice	☐ Hepatitis	☐ Indigestion
☐ Loss of Appetite	☐ Heartburn	☐ Ulcers
☐ Hernia	☐ Hiatal Hernia	☐ Tumors
☐ Polyps	☐ Cancer	☐ Vomiting
☐ Enlarged Liver	☐ Surgery	☐ Other

URINARY SYSTEM

☐ Kidney Diseases	☐ Bloody Urine	☐ Bladder Infection
☐ Painful Urination	☐ Frequent Urination	☐ STD's
☐ Transplants	☐ Dialysis	☐ Other

ALLERGIES

☐ Insect Stings	☐ Cosmetics	☐ Shampoos
☐ Anesthetics	☐ Soaps	☐ Latex
☐ Dyes	☐ Detergents	☐ Pollens
☐ Food	☐ Dust	☐ Medications
☐ Eggs	☐ Hay Fever	☐ Other
☐ Jewelry		

NERVOUS SYSTEM

☐ Numbness	☐ Seizure	☐ Stroke
☐ Convulsion	☐ Loss of Speech	☐ Blackout
☐ Panic	☐ Suicidal	☐ Alcoholism
☐ Paralysis	☐ Tingling	☐ Dizzy Spells
☐ Headaches	☐ Breakdown	☐ Memory Coordination
☐ Depression	☐ Emotional	☐ Pressured
☐ Tiredness	☐ Epilepsy	☐ Other

IMMUNIZATIONS

☐ Tetanus	☐ Polio	☐ German Measles
☐ Hepatitis	☐ Other	☐ Childhood Immunizations

OB/GYN

☐ Irregular Periods	☐ Ovarian Surgery	☐ Fallopian Surgery
☐ Birth Control Pills	☐ Cancer	☐ Abnormal Bleeding
☐ Are You Pregnant?_____		☐ Menopause
☐ Nursing	☐ Other	☐ Hormone Replacement Therapy

Your Physician_____ **Physician's Phone Number**_____

When did you last see your physician?_____

Please list any medications you take periodically or regularly:

Please list any medications or foods that you are allergic to or have had reactions to:

Please describe any conditions you have checked as "Other" or any unlisted health problems we should know about:

I certify that the information given above is true and complete. I understand that I am responsible for the cost of dental treatment regardless of insurance coverage and agree to pay all charges for my (or my dependent's) dental care.

Signature_____ **Date**_____

INSURANCE RELEASES

I have reviewed the proposed treatment plan. I authorize release of any information related to this claim.

Signed (Patient or Parent if a minor)

I hereby authorize payment to Daniel E. Hogan, D.M.D. of the group insurance benefits otherwise payable to me.

Signed (Insured Person)

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Reviewed by: _____ **Date:** _____