Hoffman & Arthur, DDS, PA
Patient Information

Patient's Last Name__________________________**First Name**____________________________**MI**_______**Birthdate**____/____/_____

Prefers the Name_________________________**Soc Sec #**_______-____-________**Male [ ] Female [ ] Marital Status**________________

Address/City/State/Zip____

Phone Numbers: Home___________________**Work**___________________**Mobile**___________________**Other**___________________

Parent's Name, if minor______________________________________**Soc Sec #**______-_____-_________**Birthdate**____/____/________

Spouse's Name, if applicable__________________________________**Soc Sec #**_______-_____-_________**Birthdate**___/____/_________

Who referred you to us____**Their relationship to you**___________________________

Employer/Insurance Information

Primary Dental Insurance____**Employer**______________________________________

Policyholder's Name_______________________________________**Soc Sec #**_______-____-__________**Birthdate**_____/____/________

Secondary Dental Insurance____**Employer**_____________________________________

Policyholder's Name_______________________________________**Soc Sec #**_______-_____-_________**Birthdate**_____/_____/_______

Dental History

Reason for today's visit_________________________________**Previous Dentist's Name/Phone #**________________________________

Last dental visit was on_________________**Last x-rays were taken on**________________**How often do you brush?** ______ **Floss?** _____

Do you have any other dental problems now? If yes, please describe: [ ] No [ ] Yes,____

Is there anything else about having dental treatment that you would like us to know? ____

Medical History

Primary Physician's Name____**Phone #**_________________________________

Have you been under the care of a doctor during the past 2 years? If yes, explain: ____

Are you taking any medication, drugs or pills now, including regular dosages of aspirin? If yes, explain: __________________________

Are you allergic to any medication or substances? If yes, explain: ____

Please indicate which of the following you have had, or have at present:

[ ] Heart (Surgery/Disease/Attack)	[ ] Stroke	[ ] Hepatitis A or B
[ ] Congenital Heart Disease	[ ] Diabetes	[ ] H.I.V. Positive
[ ] Heart Murmur	[ ] Thyroid Problems	[ ] Hemophilia
[ ] High Blood Pressure	[ ] Tuberculosis	[ ] Sickle Cell Disease
[ ] Mitral Valve Prolapse	[ ] Liver Disease	[ ] Cold Sores/Fever Blisters
[ ] Artificial Heart Valve	[ ] Sinus Trouble	[ ] Epilepsy or Seizures
[ ] Heart Pacemaker	[ ] Allergies/Hives	[ ] Fainting or Dizzy Spells
[ ] Rheumatic Fever	[ ] Asthma	[ ] Chemotherapy
[ ] Artificial Joints (hip, knee, etc.)	[ ] Latex Sensitivity	[ ] Radiation Therapy
[ ] Contact Lenses	[ ] Diet (Special/Restricted)	[ ] Psychiatric/Psychological Care

Do you have any disease, condition or problem not listed? If so, please list: ____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge and will notify the doctor of any change in my health or medication. I understand I am financially responsible for any and all fees, including those not covered and/or paid by insurance, if applicable. I authorize payment of the dental benefits otherwise payable to me directly to Hoffman & Arthur, DDS, PA and to the extent permitted under applicable law, I authorize release of information relating to services provided in order to obtain payment.

Patient's Signature (Parent, if minor)____**Date**____________________________________