HAGEN
Family & Cosmetic Dentistry
HEATHER HAGEN, D.D.S.

WELCOME

1 About You

Today's Date:_____

E-mail Address:_____

Name:_____ I prefer to be called:_____
LAST FIRST MI MR MRS MS DR

Male Female Birthdate:____/____/____ Age:_____ SS #:_____

Single Married Divorced Widowed Separated DL #: _____

Home Address:_____
APT/CONDO #

_____
CITY STATE ZIP

Hm #: (____)_____ Cell #: (____)_____ Wk #: (____)_____ Ext:_____

Where & when are the best times to reach you?_____

Employer:_____ Occupation: _____

How did you hear about us?_____ Other family members seen by us:_____

Previous / Present Dentist: _____Last Visit Date:_____

2 Spouse Information

His/Her Name:_____

Birthdate:____/____/____ Age:_____

SS #:_____ DL #:_____

Cell #: (____)_____

Wk #: (____)_____ Ext:_____

In the event of an emergency, who should we contact?

His/Her Name:_____

Relation:_____

Best Contact #: (___)_____

Additional Contact #: (___)_____

3 Dental Insurance

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #:_____

Group # (Plan, Local or Policy #):_____

Insured's Name:_____

Insured's Birthdate:____/____/____

Insured's ID#:_____

Insured's Employer:_____

4 Dental History

Why have you come to the dentist today?_____

Are you currently in pain? Yes No if yes, please explain_____

Do you require antibiotics before dental work? Yes No

Have you ever had a serious problem associated with previous dental work? Yes No

if yes, please explain_____

Have you ever had a negative dental experience? Yes No

if yes, please explain_____

Do you now or have you ever experienced pain/discomfort/pop or click in your jaw joint (TMJ/TMD)? Yes No

Your current dental health is: Good Fair Poor

Do you like the appearance of your teeth? Yes No

if no, what would you like to be changed?_____

Do your gums ever bleed? Yes No

Have you ever had periodontal disease? Yes No

How many times a week do you floss?_____ How many times a day do you brush?_____

Type of toothpaste?_____ Type of bristles? Hard Medium Soft

5 Medical History

Physician's Name:_____ Wk #: (_____)_____

Date of last visit:_____

Currently under the care of a physician? Yes No Please Explain: _____

Your current physical health is: Good Fair Poor

Are you taking any prescription/over-the-counter or supplemental drugs? Yes No

Please list each one:_____

_____

Do you smoke or use tobacco? Yes No if yes, how long/amount_____

Ever taken Fosamax, or any biophosphonate? Yes No Ever taken Phen-Fen? Yes No

For Women:

Using a prescribed method of birth control? Yes No

Are you pregnant? Yes No Week #_____

Are you nursing? Yes No

Have you ever had any of the following disease or medical problems?
(Please circle the option that applies)

Blood Disorder

Y N Anemia
Y N Hemophilia/Abnormal Bleeding
Y N Blood Transfusion
Y N HIV+/AIDS
Y N Sickle Cell Disease/Traits

Digestive

Y N Colitis
Y N Heart Burn
Y N Reflux
Y N Ulcers

Endocrine

Y N Diabetes
Y N Kidney
Y N Liver
Y N Thyroid

Heart

Y N Congenital Heart Defect
Y N Heart Murmur
Y N High/Low Blood Pressure
Y N Mitral Valve Prolapse

Respiratory

Y N Asthma
Y N Difficulty Breathing
Y N Emphysema
Y N Sinus Problems

Other

Y N Arthritis
Y N Artificial Bones/Joints/Valve
Y N Autoimmune Disease
Y N Drug/Alcohol Abuse
Y N Epilepsy/Seizures/Fainting Spells
Y N Fever Blisters/Herpes
Y N Glaucoma
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Tuberculosis (TB)
Y N Venereal Disease

Y N Cancer/Chemotherapy Date:_____ Type:_____
Y N Heart Attack/Stroke Please explain/Date:_____
Y N Hepatitis - Please circle type: A B C D
Y N Heart Surgery/Pacemaker Date:_____
Y N Other:_____

Please list any serious medical condition(s), hospitalizations or surgeries that you have ever had:

_____
_____
_____
_____
_____

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Penicillin Y N Codeine Y N Jewelry/Metals
Y N Tetracycline Y N Dental Anesthetics Y N Latex Y N Sulfa Y N Gluten
Y N Dairy Y N Other

Please list any other drugs/materials that you are allergic to:_____

_____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. **I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.**

Reviewed By Dentist

_____ _____
Patient Signature **Date** **Dr. Signature** **Date**