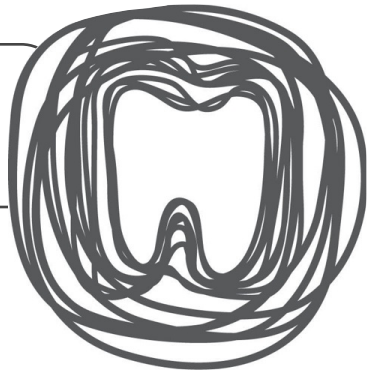
HAGEN
Family & Cosmetic Dentistry
HEATHER HAGEN, D.D.S.

WELCOME



1 About You

Today's Date:_____

E-mail Address:_____

Name:_____
LAST FIRST MI MR MRS MS DR

I prefer to be called:_____ ☐ Male ☐ Female

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

Home Address:_____
APT/CONDO #

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

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

Wk #: (____)_____ Ext:_____

DL #: _____

Employer:_____

How long there? _____ Occupation: _____

Where & when are best times to reach you?_____

Whom may we thank for referring you?_____

Other family members seen by us:_____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date:_____

2 Spouse Information

His/Her Name:_____

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

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

Wk #: (____)_____ Ext:_____

DL #: _____

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:_____

Employer's Address:_____

Secondary 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:_____

Employer's Address:_____

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

His/Her Name:_____

Relation:_____

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

4 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

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)

Y N Anemia/Radiation Treatment
Y N Artificial Bones/Joints/Valves
Y N Arthritis
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema/Glaucoma
Y N Epilepsy/Seizures/Fainting Spells
Y N Fever Blisters/Herpes
Y N Heart Attack/Stroke
Y N Heart Murmur
Y N Heart Surgery/Pacemaker
Y N Hemophilia/Abnormal Bleeding
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized for any reason
Y N Kidney Problems/ Liver
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sickle Cell Disease/Traits
Y N Sinus Problems
Y N Thyroid
Y N Tuberculosis (TB)
Y N Ulcers/Colitis
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

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

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

_____

5 Dental History

Why have you come to the dentist today?

_____

_____

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

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

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

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

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 bristles? Hard Medium Soft

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.**

_____
Signature **Date**

Reviewed By Dentist

_____
Dr. Signature **Date**