HEALTH HISTORY/REGISTRATION SUSAN ION HOGAN, DDS, PA

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

Have we seen anyone in your family, if so, who? _____

Patient's Name _____ Birth date _____ e-mail _____
Address _____ City/St _____ Zip _____
Home Phone _____ Business Phone _____ Cell Phone _____
Occupation _____ Employer _____ Spouse's Name _____
Dental Insurance _____ Policy No. _____ Benefits Phone _____
Subscriber's Name _____ Subscribers Employer _____
Subscriber's SS # _____ Subscribers Birth Date _____
Person Financially Responsible _____
Person to contact in Case of Emergency _____ Phone _____

Medical History

PHYSICIAN _____ Do you have an existing illness? _____

Check any of the following that apply:

☐ HIGH BLOOD PRESSURE	☐ BLOOD DISEASE	☐ HEPATITIS	☐ COLD SORES
☐ HEART SUGERY	☐ BLOOD TRANSFUSION	☐ AIDS/HIV	☐ SINUS TROUBLE
☐ ANGINA	☐ HEMOPHILIA	☐ ULCERS	☐ APTHOUS ULCERS
☐ PACEMAKER	☐ EPILEPSY	☐ GLAUCOMA	☐ ANTIBIOTIC / MED ALLERGY
☐ IRREGULAR BEAT	☐ TUMOR HISTORY	☐ TUBERCULOSIS	☐ LATEX ALLERGY
☐ STROKE, HEART ATTACH	☐ CANCER RADIATION	☐ EMPHYSEMA LUNG DISEASE	☐ PREGNANCY
☐ PROSTHETIC HEART VALVE	☐ CHEMOTHERAPY	☐ ASTHMA	☐ NURSING
☐ MITRAL VALVE PROLAPSE	☐ LIVER OR KIDNEY DISEASE	☐ RECENT WEIGHT CHANGE	☐ BIRTH CONTROL PILLS
☐ ARTIFICIAL HIP/KNEE	☐ OSTEOPOROSIS	☐ ANOREXIA / BULIMIA	☐ HORMONE REPLACEMENT
☐ DIABETES	☐ ARTHRITIS	☐ ANEMIA	

Other: _____

Have you been hospitalized in the last 2 years? ___ If so, please explain? _____
_____
Do you take any kind of blood thinner meds? _____ If so, what? _____
Do you take (or have taken) any kind of bisphosphonate meds? (for bone strength)
If so, what? _____ When? _____ For how long? _____
Have you taken any steroid meds in the last 2 years? ____ If so, what? _____
For how long? _____
Do you have any allergies _____ if so what? _____
Do you smoke? _____

LIST MEDICATIONS(list on back if nec.) _____
_____
_____
MAIN DENTAL CONCERN:. _____
Last Dental Visit? _____ Reason? _____
When was your last Cleaning? _____ Last X-Rays? _____
HAVE YOU HAD ANY ADVERSE REACTION TO LOCAL ANESTHETICS? _____
Are you aware of grinding or clenching? _____ Do you have pain in jaw, neck, or face? _____
Is there anything else you would like us to know? _____

I, the undersigned consent to examination and treatrment agreed to be necessary. I realize the risks involved. I agree to assume responsibility for fees accosicated with these procedures.

Patient / Guardian Signature _____ Date _____