Family & Cosmetic
DENTISTRY
STEVEN R. HAGERMAN, DDS
Advanced dental care for a healthy, beautiful smile

Personal History

Patient Name ______________________ Date __________ Birthdate ______________

Home Address ______________________ City ______________________ Zip ________

Social Security Number ____

Parent or Legal Guardian ______________________ Address ______________________

Phone ______________________

Person Responsible for Account Balance ______________________________________

Social Security Number of Responsible Party __________________________________

Who should we call in case of emergency? ______________________ Phone ______________________

Is the Patient covered by Dental Insurance? Yes__________ No__________

Name of Insurance Company ______________________ Policy # ______________________

Policy Holder's Name ______________________ Birthdate ______________________

Has the Patient ever had an upsetting experience in the Dental Office?

If yes, please explain ____

How did you hear about our office? ____

Dental Information

Reason for visit ______________________ Is this the Patient's 1st Dental Visit? ______

Date of last cleaning and exam ______________________ Date of last treatment ______________________

Date of last physical examination by a Medical Doctor ______________________

Physicians Name, Address and Phone Number ______________________________________

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Medical Information

Yes	No	
☐	☐	Has Patient ever been hospitalized for a serious illness or operation?
☐	☐	Does patient have or have they had any of the following diseases?
☐	☐	1) Heart problems-heart defect, heart murmur,
☐	☐	rheumatic fever, scarlet fever,
☐	☐	rheumatic heart disease,
☐	☐	heart surgery or mitral valve prolapse.
☐	☐	2) Liver problems-Hepatitis or jaundice?
☐	☐	3) Lung or breathing problems-asthma, hay fever, sinus trouble, allergies?
☐	☐	4) Diabetes?
☐	☐	5) Thyroid problems?
☐	☐	6) Kidney trouble, Kidney transplant or dialysis?
☐	☐	7) Ear or Hearing Problems?
☐	☐	8) Fainting spells or seizures?

Yes	No	
☐	☐	9) Chemical dependency (drugs or Alcohol)?
☐	☐	10) Had adnormal bleeding associated with previous tooth extractions, surgery or injuries?
☐	☐	11) Blood Transfusions?
☐	☐	12) Eye problems?
☐	☐	13) Is patient taking any medications at the present time? If so, please list ______________
☐	☐	14) Has Patient ever had any allergic reactions to any medications, Penicillin, Antibiotics, sulfa aspirin, other?
☐	☐	15) Any blood disorder, anemia, or leukemia?
☐	☐	16) Does any one in your family have any disability, birth defects or growth related problems?
☐	☐	17) Can you think of any other disease condition or problem not listed Above that I should know about? ______________ ______________

If yes to any of the above, please explain:

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Signature ____ Date ______________

(Patient or parent/guardian if patient is under age 18)

The undersigned, hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

____ Date ______________

Authorized Signature of Covered Person/Employee