Paul Hanna Dental, LLC
157 N 100 E, Roosevelt, UT 84066

PATIENT INFORMATION

Name: _____ Sex: ☐M ☐F Preferred Name:_____

Birthdate: _____ Age:_____ SSN #_____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Address: _____ City: _____ State_____Zip _____

Home Ph: _____ Work: _____ ____Cell: _____

Email_____

Is it ok to contact you via (check all that apply) □ Email □ Cell Phone □ Text Message □ Home □ Work

PARENT / GUARDIAN INFORMATION

Person Responsible for Patient (If different from above):_____Relationship to Patient:_____

Birthdate:_____ SSN _____ Phone: _____ Alt. Ph _____

BILLING INFORMATION

I have Dental Insurance. Insurance Company_____

☐ I would like to pay my estimated portion by Cash or Check at time of service.
☐ I would like to pay my estimated portion by Credit Card at time of service.
☐ I would like to apply for an extended payment plan option.

Insured Party _____ Insurance ID # _____

I do not have Dental Insurance.

☐ I would like to pay by cash or check at time of service
☐ I would like to pay by Credit Card at time of service.
☐ I would like to apply for an extended payment plan.

EMERGENCY CONTACT INFORMATION

Emergency Contact_____ Phone #_____

Medical Doctor _____ Phone #_____ Date of last visit _____

MEDICAL HISTORY

Have you ever had any serious illnesses or operation? ☐ YES ☐ NO If yes, please describe_____

Have you ever had a blood transfusion? ☐ YES ☐ NO If yes, please give approximate date:_____

Are you currently taking any blood thinner medications? YES NO _____

Females: *Are you Pregnant?* ☐ YES ☐ NO *Nursing?* ☐ YES ☐ NO *Taking birth Control Pills?* ☐ YES ☐ NO

☐ AIDS	☐ FAINTING SPELLS	☐ PACEMAKER
☐ ARTHRITIS	☐ HEADACHES	☐ IMPLANTED DEFRIBRILLATOR
☐ ARTIFICIAL HEART VALVES	☐ HEART MURMUR	☐ RESPIRTORY DISEASE
☐ ARTIFICIAL JOINTS	☐ HEART CONDITION	☐ RHEUMATIC FEVER
☐ ASTHMA	☐ BEHAVIORAL PROBLEMS	☐ SCARLET FEVER
☐ ANXIETY / PANIC ATTACKS	☐ HEMOPHILIA	☐ SHORTNESS OF BREATH
☐ BACK PROBLEMS	☐ HEPATITUS: TYPE _____	☐ SICKLE CELL DISEASE/TRAIT
☐ BLOOD DISEASE	☐ HIGH BLOOD PRESSURE	☐ STROKE
☐ CANCER	☐ HIV POSITIVE	☐ TONSILLITIS
☐ CHEMICAL DEPENDENCY CHEMOTHERAPY	☐ JAW PAIN	☐ TUBERCULOSIS
☐ CONGESTIVE HEART FAILURE	☐ KIDNEY DISEASE/DIALYSIS	☐ VENEREAL DISEASE
☐ DIABETES	☐ MITRAL VALVE PROLAPSE	☐ DEVELOPMENTAL PROBLEMS
☐ EPILEPSY/SEIZURES	☐ OSTEOPOROSIS	Other Allergies _____

Please "X" any that you are allergic to: ☐ Amoxicillin ☐ Anesthetics ☐ Asprin ☐ Codeine ☐ Latex ☐ Tylenol ☐ Ibuprofen

Have you ever taken Fen-Phen?..... ☐ Yes ☐ No If so, have you had your heart evaluated? _____

Have you ever taken Fosmax, Boniva or any other drugs to decrease resorption of bone as in osteoporosis or any drugs for metastatic bone cancer?_____

Please list any other medications you are currently taking: _____

Who can we thank for referring you to us today?

I request and authorize the office of Paul Hanna Dental, LLC to examine, clean and provide necessary dental treatment for me/the patient. I further request and authorize the taking of dental x-rays/photographs as may be considered necessary for diagnostic or educational purposes. I will be responsible for any charges incurred on this account.

SIGNATURE:_____ DATE:_____ WITNESS:_____

Parent, Legal Guardian or Authorized Agent of Patient

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DENTAL HEALTH

Date of your last dental visit:_____/_____/_____ Date of your last dental cleaning: _____/_____/_____

What is the primary concern that you would like us to address first? _____

Have you ever had serious problems associated with previous dental treatment?_____ ☐ Yes ☐ No

If so, please explain: _____

What, if anything, happened in a previous dental experience that was a reason to not return? _____

Do you have missing teeth? _____ ☐ Yes ☐ No If so, have they been replaced? _____ ☐ Yes ☐ No

Do you feel (or been told) that you do not have fresh breath? _____ ☐ Yes ☐ No

How many times per day do you brush your teeth? _____ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ more

What type of brush do you use?.....Soft ☐ Medium ☐ Hard ☐ What brand? _____

How many times per week do you floss your teeth?.....<1.....2.....3.....4.....more

Do you use a mouthwash or rinse?.....Yes ☐ No ☐ If so, what brand?_____

Do you routinely clean your tongue by brushing or using a tongue scraper?.....Yes ☐ No ☐

Do your gums bleed or become sensitive while brushing or flossing?.....Yes ☐ No ☐

Have you ever been treated for periodontal (gum) disease?.....Yes ☐ No ☐

Do you have areas where your gums have receeded?.....Yes ☐ No ☐

Do you currently have pain in any of your teeth?.....Yes ☐ No ☐

Do you have sensitivity to any of the following? Cold ☐ Hot ☐ Sweets ☐ Biting

Are any of your teeth loose?.....Yes ☐ No ☐ Which ones?_____

Do you ever have popping, clicking, or pain in your jaw joint?.....Yes ☐ No ☐

Do you have frequent headaches or pain in your neck or shoulders?.....Yes ☐ No ☐

Do you clench or grind your teeth while sleeping or awake?.....Yes ☐ No ☐

If so, do you wear a nightguard or bite appliance? .....Yes ☐ No ☐

Have you ever had orthodontic treatment (braces)?.....Yes ☐ No ☐

If so, do you wear a retainer?.....Yes ☐ No ☐

Do you have dental implants?.....Yes ☐ No ☐

If so, when were they placed?_____

Do you ever have sores or ulcers in your mouth?.....Yes ☐ No ☐

Please describe any complications you may have had following previous dental treatment.

How did you hear about us? _____

PHOTOGRAPHIC RELEASE AND CONSENT:

☐ Yes you may use my testimonial, photos and name to let other patients know about my great experience with your office.

I hereby consent and authorize the office of Paul Hanna Dental, LLC to take photographs, slides and / or videos of my face, jaws, and teeth. I understand that the photographs, slides, and / or videos will be used as a record of my care, and may be used with or without my given name or with a fictitious name for educational purposes in demonstrations, advertising in printed media and / or websites, professional publications (dental magazines and journals) and any other lawful purpose.

I release and forever discharge the office of Paul Hanna Dental, LLC and its designated representatives from any claim, demands, or liability on account of such use or for the quality of the reproduction of the image.

SIGNATURE:_____ DATE:_____ WITNESS:_____

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