MARK R. HANSELMAN, D.D.S.

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HEALTH HISTORY

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Bus. Phone _____ Email _____

Employed By _____ Present Position _____

Spouse's Name _____ Employed By _____

Referred By _____

PRIMARY INSURANCE COMPANY

Name _____

Address _____

_____

Group# _____

INSURED PARTY

Name _____

Relation to Insured Self Spouse Child Other

Date of Birth _____ S.S.#/Ins. ID# _____

Address _____

SECONDARY INSURANCE COMPANY

Name _____

Address _____

_____

Group# _____

INSURED PARTY

Name _____

Relation to Insured Self Spouse Child Other

Date of Birth _____ S.S.#/Ins. ID# _____

Address _____

Who will be responsible for your account? _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependant(s) have insurance coverage with _____.
I understand that I am financially responsible for all charges whether or not paid by insurance and authorize the use of my signature on all insurance submissions.

Mark R. Hanselman, D.D.S. may use my health care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Print Name of Patient, Parent, Guardian or Representative — Relationship to Patient

HEALTH HISTORY

1.) Have you been under the care of a medical doctor or hospitalized during the past two years?_____

If YES, for what?_____

2.) Physicians Name _____ Phone _____

3.) Please list the names and dosages of any prescription drugs or medications (OTC, herbal) you are taking_____

4.) Please check if you have had any of the following:

❏ Any Heart Condition_____
❏ Heart valve replacement or repair:
Surgery Date _____
❏ Antibiotic treatment prior to dental treatment
❏ High or Low Blood Pressure:
Last BP reading_____
❏ Pacemaker

❏ Respiratory Conditions _____
❏ Asthma
❏ Emphysema
❏ Tuberculosis
❏ Sinus Trouble
❏ Hay Fever

❏ Allergies
❏ Medications or Drugs_____
❏ Anesthetics _____
❏ Latex
❏ Other allergies to _____

❏ Arthritis
❏ Diabetes
❏ Kidney Condition
❏ Liver Disease
❏ Thyroid-Hyper or Hypo
❏ Epilepsy or Seizures
❏ Measles
❏ Mumps

❏ Circulatory Conditions _____
❏ Blood Disorders _____
❏ Hepatitis Type and Treatment_____
❏ Anemia, Excessive Bleeding
❏ Stroke/TIA
❏ AIDS/HIV Positive

❏ Cancer Type_____
❏ Malignancies/Tumors: Area of Body _____
❏ Radiation Treatments: Area of Body _____
❏ Chemotherapy

❏ Joint Replacement_____
Area of Body _____
Year or Replacement _____
Physician _____

❏ Ulcer
❏ Restricted Diet_____ Why?_____
❏ Nervous/Anxious
❏ Psychiatric/Psychological Care or Conditions
❏ Substance Abuse (alcohol, drug)

❏ Tobacco Use (pipe, cigar, cigarette, chew)
❏ How much per day/How long? _____

❏ Other Diseases or Conditions not listed
Please List_____

5.) FEMALES: Are you pregnant? _____ How many months? _____
Nursing? _____ Taking Birth Control Pills? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date_____

DENTAL HISTORY

What is the reason for your visit today?_____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth XC-Rays_____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ City _____Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss?_____

What other dental aids do you use? (electric toothbrush, toothpick, etc.)_____

Do you have any dentral problems now: YES NO

If YES, please describe _____

Are any of your teeth sensitive to:

Hot or cold? Yes No
Sweets? Yes No
Biting or Chewing? Yes No
Have you noticed any mouth odors or bad tastes? Yes No
Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No
Have your parents experienced gum disease or tooth loss? Yes No
Have you noticed any loose teeth or change in your bite? Yes No
Does food tend to become caught in between your teeth? Yes No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep? Yes No
Bite your lips or cheeks regularly? Yes No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No
Mouth breathe while awake or asleep? Yes No
Have tired jaws, especially in the morning? Yes No
Smoke / chew tobacco? Yes No

Have you ever had:

Orthodontic treatment? Yes No
Oral Surgery? Yes No
Periodontal treatment? Yes No
Your teeth ground or the bite adjusted? Yes No
A bite plate or mouth guard? Yes No
A serious injury to the mouth or head? Yes No
If so, please describe, including cause_____
_____

Have you experienced:

Clicking or popping of the jaw? Yes No
Pain? (joint, ear, side of face) Yes No
Difficulty in opening or closing mouth? Yes No
Difficulty in chewing on either side of the mouth? Yes No
Headaches, neckaches or shoulder aches? Yes No
Sore muscles (neck, shoulders?) Yes No

Are you satisfied with your teeth's appearance? Yes No
Would you like to keep all your teeth all your life? Yes No
Do you feel nervous about having dental treatment? Yes No
If so, what is your biggest concern?
_____
Have you ever had an upsetting dental experience? Yes No
If yes, please describe _____
_____

Is there anything else about having dental treatment that you would like us to know? _____

If yes, please describe_____

_____

REVIEW - UPDATE

DATE	