



KEITH A. HOOVER, DDS
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Tel: (330) 650-0360

39 Milford Drive
 Hudson, Ohio 44236

PATIENT INFORMATION

Date: _____ NEW PATIENT UPDATE

Patient: _____

LAST FIRST MI PREFERRED TITLE

MALE FEMALE CHILD* STUDENT** SINGLE MARRIED DIVORCED WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW: _____ **IF STUDENT, PLEASE COMPLETE: FULL-TIME PART-TIME

PARENT/GUARDIAN NAME(S) _____ SCHOOL/LOCATION _____

Patient Date of Birth: _____ Patient SSN: _____

Address: _____

ADDRESS LINE 1 _____

ADDRESS LINE 2 _____

CITY ST ZIP CODE

E-Mail: _____

HOME: _____

CELL: _____

OTHER: _____

PAGER: _____

FAX: _____

Referral? Yes No Referred by: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME RELATIONSHIP Tel: _____

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Address: _____

ADDRESS LINE 1 _____

ADDRESS LINE 2 _____

CITY ST ZIP CODE

E-Mail: _____

WORK: _____

DIRECT: _____

OTHER: _____

PAGER: _____

FAX: _____

INSURANCE INFORMATION

Subscriber: _____

LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: _____ Subscriber SSN: _____

Subscriber Employer: _____

Patient Relationship to Subscriber: SELF SPOUSE CHILD OTHER

PRIMARY INSURANCE CARRIER: _____

Group/Policy No.: _____ ID No.: _____

Address: _____

CITY ST ZIP CODE

TEL: _____

TOLL-FREE: _____

FAX: _____

SECONDARY INSURANCE CARRIER: _____

Group/Policy No.: _____ ID No.: _____

Address: _____

CITY ST ZIP CODE

TEL: _____

TOLL-FREE: _____

FAX: _____



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PREVIOUS DENTIST INFORMATION

Dentist: _____ Telephone: _____
 Clinic/Facility: _____
 Address: _____

 CITY ST ZIP CODE
 Reason for changing: _____

DENTAL HISTORY

ORAL HEALTH: EXCELLENT GOOD FAIR POOR
 Date of Last Dental Visit: _____ Treatment Type: _____
 When do you brush your teeth? _____ Do you floss? Y N Mouthwash? Y N
 Y N Are you currently having dental discomfort? If yes, explain: _____
 Y N Any unhappy/unpleasant dental experiences? If yes, explain: _____
 Y N Any injuries to mouth/teeth/head? If yes, explain: _____
 Y N Have you had any teeth removed?
 Y N Other than wisdom teeth or teeth removed for orthodontic reasons, have missing teeth been replaced?
 Y N Orthodontic appliances now or in the past?
 Y N Gums bleed when brushing or flossing?
 Y N Concerned about gum disease? History of gum disease? Y N
 Y N Any concerns about the appearance of your teeth?
 Y N Does it hurt to bite or chew? Do you have hot or cold sensitivity? Y N
 Y N Do you clench or grind your teeth? If so, do you wear a night guard or splint? Y N
 Y N Do you hear popping or clicking noises when you chew?
 Y N Does any type of dental treatment make you nervous? If yes, please explain below:

 Y N Have you whitened your teeth? What method(s) have you used? _____
 The most important concerns regarding my dental treatment are:

 What factors are most important for your satisfaction with our office?

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:
 Y N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)
 Y N Any unusual speech habits? If yes, explain: _____
 Y N Does the patient receive assistance with brushing and flossing? If yes, how often? _____
 Y N Has your child had any previous dental visits?
 Y N Does your child like to come to the dentist?

PRIMARY PHYSICIAN INFORMATION

Physician: _____ Telephone: _____
 Clinic/Facility: _____



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MEDICAL HISTORY

GENERAL HEALTH: EXCELLENT GOOD FAIR POOR

- Y N Under a physician's care now?
- Y N Any hospitalization in the past 5 years? _____
- Y N Any serious illnesses/surgeries? _____
- Y N Use tobacco in any form? If Yes, Type: _____
- Y N Is pre-medication required before dental visits due to heart condition or artificial joint?
- Y N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: Y N Currently nursing? Y N Currently pregnant? Due Date: _____

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? Y N
If yes, please describe: _____

Is there anything important about your medical condition we have not asked? Y N If yes, please describe: _____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): NONE

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> ACID REFLUX | <input type="checkbox"/> BULIMIA | <input type="checkbox"/> HEARING PROBLEMS | <input type="checkbox"/> PACEMAKER |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> CANCER/MALIGNANCY | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> PSYCHIATRIC TREATMENT |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> CEREBRAL PALSY | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> RADIATION/CHEMO |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> CHEMICAL DEPENDENCY | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> RESPIRATORY DISEASE |
| <input type="checkbox"/> ANOREXIA | <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ANXIETY | <input type="checkbox"/> CONVULSIONS | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> ARTIFICIAL JOINTS | <input type="checkbox"/> DIABETES | <input type="checkbox"/> LIVER PROBLEMS | <input type="checkbox"/> THYROID CONDITION |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> MEASLES | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> EPILEPSY/SEIZURES | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> AUTISM/ASPERGER'S | <input type="checkbox"/> FREQUENT EAR INFECTIONS | <input type="checkbox"/> MONONUCLEOSIS | <input type="checkbox"/> VENEREAL DISEASE |
| <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> FREQUENT HEADACHES | <input type="checkbox"/> MUMPS | <input type="checkbox"/> OTHER: _____ |

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

- | | | | | |
|---|----------------------------------|---|---|-------------------------------|
| <input type="checkbox"/> ASPIRIN | <input type="checkbox"/> CODEINE | <input type="checkbox"/> LACTOSE INTOLERANCE | <input type="checkbox"/> SLEEPING PILLS | <input type="checkbox"/> NONE |
| <input type="checkbox"/> ANESTHETIC – LOCAL | <input type="checkbox"/> DAIRY | <input type="checkbox"/> METAL SENSITIVITY | <input type="checkbox"/> SULFA DRUGS | |
| <input type="checkbox"/> BARBITURATES | <input type="checkbox"/> LATEX | <input type="checkbox"/> NITROUS OXIDE SEDATION | <input type="checkbox"/> PENICILLIN/OTHER ANTIBIOTICS | |
| <input type="checkbox"/> OTHER – PLEASE LIST: _____ | | | | |

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): NONE

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> ANTIBIOTICS/SULFA DRUGS | <input type="checkbox"/> ANTIHISTAMINES/ALLERGY | <input type="checkbox"/> DAILY ASPIRIN | <input type="checkbox"/> BLOOD PRESSURE MEDICATIONS |
| <input type="checkbox"/> BLOOD THINNERS | <input type="checkbox"/> CANCER/CHEMO MEDICATIONS | <input type="checkbox"/> CORTISONE/STEROIDS | <input type="checkbox"/> HEART MEDICATION/DIGITALIS |
| <input type="checkbox"/> INSULIN | <input type="checkbox"/> NITROGLYCERIN | <input type="checkbox"/> ORAL CONTRACEPTIVES | <input type="checkbox"/> OSTEOPOROSIS MEDICATIONS |
| <input type="checkbox"/> OTHER DIABETIC MEDICATIONS | <input type="checkbox"/> RECREATIONAL DRUGS | <input type="checkbox"/> THYROID MEDICATIONS | <input type="checkbox"/> TRANQUILIZERS |
| <input type="checkbox"/> OTHER (VITAMINS) | | | |

DRUG NAME	DOSAGE	REASON PRESCRIBED