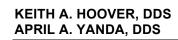


KEITH A. HOOVER, DDS APRIL A. YANDA, DDS

www.drshooverandyanda.com

Tel: (330) 650-0360 39 Milford Drive Hudson, Ohio 44236

PATIENT INFORMATION								
Date: Patient:					□N	IEW PATIENT	□UPDATE	
	LAST FIRST			MI	MI PREFERRED TITLE			
	□MAL	E FEMALE	□CHILD* □ST	TUDENT**	☐SINGLE ☐MARRIED	DIVORCED	□WIDOWED	
*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:				**IF STUDENT, PLEASE COMPLETE:				
PARENT/GUARDIAN NAME(S)				SCHOOL/LOCATION				
Patient Date of Birth:				Patient SSN:				
Address:	ddress: Address Line 1							
ADDRESS LINE I					Номе:			
	ADDRESS LINE	2			CELL:			
					OTHER:			
	Сітү		ST	ZIP CODE	Pager:			
E-Mail:					FAX:			
	Referral?	☐Yes ☐ No	Referred by:					
				/ INFORMATION				
In case of eaddress:	emergency, p	olease provide info	ormation for the nea	arest relative or des		erson not at	the patient's	
NAME			RELATIONSH	JID.	Tel:			
INAME				T INFORMATION				
F			EWIPLOTWIEN					
Employer: Address:				Occupation:				
Addiess.	ADDRESS LINE	E 1			Work:			
					DIRECT:			
	ADDRESS LINE	E 2			OTHER:			
					Pager:			
	CITY		ST	ZIP CODE	Fax:			
E-Mail:								
			INSURANCE	INFORMATION				
Subscriber								
Cubaaribar	LAST		FIRST	MI Cubaaribar CCN	PREFERRED		TITLE	
Subscriber	Date of Birth	1:		Subscriber SSN	I:			
		O 1	о				***************************************	
	ationship to	Subscriber:	SELF SPOUSE CHIL	D LIOTHER				
Group/Police	ov. No. :			ID No :				
Address:				15 110	TEL:			
					TOU -EREE			
					Fax:			
CEOONE	CITY	OF CARRIER.	ST	ZIP CODE				
SECONDARY INSURANCE CARRIER: Group/Policy No.: ID No.:								
Address:				ID NO	Tel:			
					TOLL-FREE:			
					FAX:			
	CITY		ST	ZIP CODE				



KEITH A. HOOVER APRIL A. YANDA & ASSOCIATES, INC.

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Tiddsoff, Offic 44230								
PREVIOUS DENTIST INFORMATION								
Dentist:	Telephone:							
Clinic/Facilit								
Address:								
Address.								
	CITY ST ZIP CODE							
Reason for								
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							
\square Y \square N	Are you currently having dental discomfort? If yes, explain:							
□Y□N	Any unhappy/unpleasant dental experiences? If yes, explain:							
□□□N □Y□N	Any injuries to mouth/teeth/head? If yes, explain:							
□Y□N □Y□N	Any injuries to mouth/teeth/head? If yes, explain: Have you had any teeth removed?							
	Other than wisdom teeth or teeth removed for orthodontic reasons, have missing teeth been replaced?							
U T □N □Y□N	Orthodontic appliances now or in the past?							
□Y□N □Y□N	Gums bleed when brushing or flossing?							
□ Y □ N	Concerned about gum disease? History of gum disease? TYTN							
□ T □ N □ Y □ N	· · · — — —							
□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? \(\subseteq Y \subseteq 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 im	portant concerns regarding my dental treatment are:							
What factor	s are most important for your satisfaction with our office?							
Wilat lactor	s are most important for your satisfaction with our office:							
CHILD/MINO	R PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:							
□Y□N	Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)							
	Tany model madice. (arams sacrang, man stang, model broathing, harding/bottle habits, paoliter, etc.)							
\square Y \square N								
\square Y \square 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/Facilit								

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MEDICAL HISTORY								
GENERAL HEALTH: DEXCELLENT 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):								
ACID REFLUX ADHD CANCER/MA AIDS/HIV CEREBRAL F ANOREXIA ANOREXIA CHICKEN PO CONVULSION ARTIFICIAL HEART VALVE ARTHRITIS ARTHRITIS ASTHMA EPILEPSY/S AUTISM/ASPERGER'S BLEEDING DISORDER ALL PATIENTS: ARE YOU ALLERGIC TO OR HA ASPIRIN CODEINE ANESTHETIC – LOCAL DAIRY	LIGNANCY PALSY PEPENDENCY DX NS N FAINTING EIZURES EAR INFECTIONS HEADACHES	HEARING PROBLEMS HEART ATTACK HEART DISEASE HEART MURMUR HEPATITIS HIGH BLOOD PRESSURE KIDNEY DISEASE LIVER PROBLEMS MEASLES MITRAL VALVE PROLAPSE MONONUCLEOSIS MUMPS ANY REACTION TO THE FOLLOWI	PACEMAKER PSYCHIATRIC TREATMENT RADIATION/CHEMO RESPIRATORY DISEASE RHEUMATIC FEVER SINUS PROBLEMS STROKE THYROID CONDITION TUBERCULOSIS ULCERS VENEREAL DISEASE OTHER: NG? (CHECK ALL THAT APPLY):					
	MEDICATION	INFORMATION						
BLOOD THINNERS □ CANCER/ □INSULIN □ NITROGL	NY OF THE FOLLOW AMINES/ALLERGY CHEMO MEDICATION YCERIN IONAL DRUGS	OWING? (CHECK ALL THAT APPLY): Daily Aspirin Blood pressure Medica						
DRUG NAME	DOSAGE	REASON PRESCRIBED						