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

www.drshooverandyanda.com
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:

Parent/Guardian Name(s)

**If Student, please complete: ☐Full-time ☐Part-Time

School/Location

Patient Date of Birth: Patient SSN:

Address:
Address Line 1
Address Line 2
City ST ZIP Code

Home:
Cell:
Other:
Pager:
Fax:

E-Mail:

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

Work:
Direct:
Other:
Pager:
Fax:

E-Mail:

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

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

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ASPIRIN
☐ANESTHETIC – LOCAL
☐BARBITURATES
☐OTHER – PLEASE LIST:
☐CODEINE
☐DAIRY
☐LATEX
☐LACTOSE INTOLERANCE
☐METAL SENSITIVITY
☐NITROUS OXIDE SEDATION
☐SLEEPING PILLS
☐SULFA DRUGS
☐PENICILLIN/OTHER ANTIBIOTICS

MEDICATION INFORMATION

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

☐ANTIBIOTICS/SULFA DRUGS
☐BLOOD THINNERS
☐INSULIN
☐OTHER DIABETIC MEDICATIONS
☐OTHER (VITAMINS)
☐ANTIHISTAMINES/ALLERGY
☐CANCER/CHEMO MEDICATIONS
☐NITROGLYCERIN
☐RECREATIONAL DRUGS
☐DAILY ASPIRIN
☐CORTISONE/STEROIDS
☐ORAL CONTRACEPTIVES
☐THYROID MEDICATIONS
☐BLOOD PRESSURE MEDICATIONS
☐HEART MEDICATION/DIGITALIS
☐OSTEOPOROSIS MEDICATIONS
☐TRANQUILIZERS

DRUG NAME	DOSAGE	REASON PRESCRIBED