Doctor Mary Ha

(847) 480 - 7670

1873 Shermer Rd
Northbrook, IL

Thank you for choosing Doctor Ha! To help us meet all your dental healthcare needs, please fill out the five boxes completely

Patient Information

Name _____ Date _____

Preferred Name:_____

Address _____

_____
city state zip

Birthdate: _____ Gender: F M Age _____

Patient SS#: _____-_____-_____

Marital Status: _____

Employer _____

Occupation _____

How did you hear of us? _____

Phone Numbers

Home Phone _____

Work _____ Cell _____

Spouse's Work _____

What is the best way to reach you? _____
Time of day? _____

Email:_____
I would like to receive e-mail reminders of my appointments
YES NO

EMERGENCY CONTACT
(Someone who does not live with you)

Name _____

Relationship _____

Phone #'s _____

Dental Insurance

Primary Dental Carrier

Subscriber Name _____ Social Security or ID# _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Ins. Claims Address: _____ Subscribers Relationship to Patient _____

_____

Secondary Dental Carrier

Subscriber Name _____ Social Security or ID# _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Ins. Claims Address: _____ Subscribers Relationship to Patient _____

_____

Insurance Authorization Statement (Sign & Date)

I hereby authorize to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment.

Signature _____ **Date** _____

This section for New Patients Only:

How can we help you?

- ☐ Overall dental health & prevention of tooth loss
- ☐ Improve the appearance of teeth/smile
- ☐ Toothache or other pain

Please describe any known dental problems: _____

Date of last cleaning? _____ **Date of last x-rays?** _____

What are your feelings about your front teeth?

Do you love your smile? _____
Is there anything you would like to change (color, spaces, crowding, shape, chips, cracks, length, gums)?

_____

Dental Update

Please let us know what you've been experiencing so we can help!

Are any teeth sensitive to cold air, ice water, sweets, or brushing?	☐ Yes ☐ No
Are any teeth sore when you chew or bite?	☐ Yes ☐ No
Do you have sensitive, tender, or swollen gums?	☐ Yes ☐ No
Do you ever have canker sores or cold sores?	☐ Yes ☐ No
Is your breath as fresh as it could be?	☐ Yes ☐ No
Do you have any sores or lumps in or near your mouth?	☐ Yes ☐ No
Have you ever seen a periodontist?	☐ Yes ☐ No

TMJ

Are you aware of clenching or grinding your teeth?	☐ Yes ☐ No
Do you have frequent headaches?	☐ Yes ☐ No
Do you wake up with or experience tired/painful jaw joints or muscles?	☐ Yes ☐ No
Have you had any head, neck or jaw injuries?	☐ Yes ☐ No

Do you require antibiotics before dental treatment?	☐ Yes ☐ No
Do you feel nervous or anxious about having dental treatment?	☐ Yes ☐ No

What did you like <u>most</u> about your last dentist? _____
What did you like <u>least</u> about your last dentist? _____
Is there anything else that you would like us to know? _____

MEDICAL UPDATE FORM

Date of last **health exam (not dental)**: _____ What was this exam for? _____

Are you currently under the care of a physician? ☒ Yes ☒ No Please explain: _____

*Please check **yes** or **no** if you have or ever had any of these conditions. These medical problems can influence your dental care. Your answers are for our records only and will be confidential. Our team may ask additional questions concerning your health.*

Heart Murmur (mitral valve prolapse)	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Epilepsy or Seizures	☐ Yes ☐ No	High or Low Blood Pressure	☐ Yes ☐ No
Stomach troubles/ Ulcers	☐ Yes ☐ No	Hepatitis/Liver Disease	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Joint Replacement, Implants, Valves	☐ Yes ☐ No
HIV Positive or AIDS Related Complex	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Emphysema or Respiratory Condition	☐ Yes ☐ No	Abnormal Bleeding from a cut	☐ Yes ☐ No
Fainting	☐ Yes ☐ No	Do you snore?	☐ Yes ☐ No

Have you been diagnosed with Sleep Apnea? ☐ Yes ☐ No
Do you use any form of tobacco products? ☐ Yes ☐ No

Do you currently use or have a history of using recreational drugs? ☐ Yes ☐ No _____

Do you take any medication for osteoporosis? ☐ Yes ☐ No _____

Have you or your family ever had any Anesethia-related problems? ☐ Yes ☐ No _____

Do you have or have you had any condition not listed? ☐ Yes ☐ No _____

Is there anything you would like to discuss alone with the doctor? ☐ Yes ☐ No _____

Women:

Are you pregnant? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No
Are you a nursing mother? ☐ Yes ☐ No

Are you allergic or have you had a reaction to:

Local Anesthetics	☐ Yes ☐ No	Codeine, Valium, other sedatives	☐ Yes ☐ No
Latex gloves, etc.	☐ Yes ☐ No	Penicillin or other antibiotics:	☐ Yes ☐ No
Aspirin	☐ Yes ☐ No	Metals (jewelry, earrings, etc.):	☐ Yes ☐ No

Please list any medications you are taking (prescription, over-the-counter, herbal) and what they are for:

_____

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. I will notify the doctor of change in health and medication.

_____ _____

Patient or Guardian Signature Date Doctor Signature Date

UPDATED HEALTH HISTORY:

_____ _____

Patient or Guardian Signature Date Doctor Signature Date