

J. MATTHEW HOGENDOBLER, D.M.D.

LINKHORN POINT PROFESSIONAL CENTER
1729 Wildwood Drive, Suite 104
Virginia Beach, Virginia 23454
757-481-5454

PATIENT ACQUAINTANCE QUESTIONNAIRE

Patient's Full Name: _____ Social Security Number: _____ - _____ - _____
Address: _____ City/State/Zip: _____
Telephone (Home): _____ (Work): _____ Date of Birth: _____ Sex: M F Marital Status: M S D W
Fax (Home): _____ (Work): _____ Email Address(es): _____
Responsible Party Full Name: _____ Social Security Number: _____ - _____ - _____
Billing Address: _____ City/State/Zip: _____
Telephone (Home): _____ (Work): _____ Employer Name: _____
Employer Address: _____ City/State/Zip: _____
Primary Dental Insurance: _____ Group Name: _____ No.: _____ Coverage: P ___ B ___ M ___ Ded ___
Secondary Dental Insurance: _____ Group Name: _____ No.: _____ Coverage: P ___ B ___ M ___ Ded ___
Insurance Card(s) Available? Y N Referred By: _____

Office Use DL

Please read carefully: Answer all questions (circle "Y" or "N"). If "Y," fill in all blanks & underline all **bold** words which apply to "Patient" above.

PATIENT MEDICAL HISTORY

Y N 1) History of adverse reaction to any medications: **Penicillin Sulfa Codeine Aspirin** other(s): _____
Y N 2) History of known allergies resulting in **hives - eczema - asthma - rashes - swelling - breathing difficulty - sinus**
Y N 3) History of **lethargy - dizziness - fainting - light headedness - seizures - shortness of breath**: _____
Y N 4) History of **night sweats - thyroid condition - epilepsy - persistent cough**: _____
Y N 5) History of **slow wound healing - poor clotting - prolonged bleeding**: _____
Y N 6) History of **jaundice - hepatitis - liver disease - swollen ankles - swollen neck glands**: _____
Y N 7) History of **high - low blood pressure - heart ailment - chest pain - rheumatic fever**: _____
Y N 8) History of **respiratory disease - bronchitis - emphysema - tuberculosis - pneumonia**: _____
Y N 9) History of **kidney - bladder - stomach - ulcer - intestinal - sexually-transmitted disease**: _____
Y N 10) History of **blood dyscrasias - diabetes - tumors - growths - benign - malignant**: _____
Y N 11) History of **heart valve - joint prosthesis - heart murmur - pacemaker**: _____
Y N 12) History of **viruses - cold sores - arthritis - immune disease - HIV - AIDS**: _____
Y N 13) History of **frequent - minor - major - headaches - ear aches** or use of **aspirin - tylenol - ibuprofen**: _____
Y N 14) History of **urinating more than 6x/day - persistent diarrhea - recent weight loss**: _____
Y N 15) Describe any major hospitalizations within past 5 years: _____
Y N 16) Are you currently in good health? Date of last physical: _____
Y N 17) Are you currently under Dr. _____'s care. Dr.'s phone #: _____
Y N 18) Are you **pregnant**? If yes, please indicate presenting **trimester** and **month**: **1st 2nd 3rd** / _____ **Month**

PATIENT DENTAL HISTORY

- Y N 19) Recent history of **red - swollen - sore - bleeding - sensitive** gums: _____
- Y N 20) Recent history of **sore spots - growths - ulcerations - lacerations - unhealed** areas in mouth: _____
- Y N 21) History of **difficult tooth extractions - dry socket** (*please explain*): _____
- Y N 22) History of **clenching - grinding - bruxing - jaw pain in front of ear - night - day - stressful lifestyle**: _____
- Y N 23) History of favoring **left - right** side of mouth while **chewing - biting**. (*In this case, "favor" means to be kind to and not use.*)
- Y N 24) Recent history of tooth sensitivities to **pressure - biting - tapping - hot - cold - sweets - other**: _____
- Y N 25) History of any adverse reaction to dental treatment or anesthetics **Novocaine - Nitrous Oxide - other**: _____

PATIENT SOCIAL HISTORY

- Y N 26) Use of **alcohol**: _____; **tobacco**: _____; non-prescription **drugs**: _____. Frequency: _____
- Y N 27) Are you concerned about your nutrition and general well-being? Please describe: _____
- Y N 28) Would you honestly welcome an improvement in your appearance? If your teeth are a concern, where? _____
- Y N 29) Do you wish to maintain the health of your teeth and gums? I currently **brush - floss - use rinses - other**: _____
- Y N 30) Are you aware healthy teeth and gums depend on what you eat & drink? How is your diet "tooth-friendly?" _____
- Y N 31) Are you aware of the correct methods of **brushing - flossing**? How often do you brush? _____ floss? _____
- Y N 32) Have you ever had instruction involving care of your teeth and gums? If yes, when was last instruction? _____
- Y N 33) Do you typically visit your **dentist - hygienist** more than once per year? If yes, how often? _____
- Y N 34) Have you had dental X-rays taken within the past 3 years? If no, when were last X-rays taken: _____
- Y N 35) Do you have any current dental complaints? If yes, please describe: _____

Please provide the names of all previous dentists patient has visited, beginning with most recent (*required*): _____

Please use this space to describe any history of mental illness and all additional medical, dental or social history not addressed above: _____

PATIENT MEDICATION HISTORY & EMERGENCY CONTACT INFORMATION

List all medications taken within past year: _____

Preferred pharmacy: _____ Location: _____ Telephone: _____

In case of emergency, notify: _____ Relationship _____ Telephone: _____

I, the undersigned patient and/or Responsible Party for Patient have read, accept and fully understand the meaning and consequences of my answers to the above statements. I acknowledge that my questions, if any, about the above inquiries have been answered to my satisfaction, and I agree to notify dentist if my status as patient's Responsible Party changes in any way. If I have listed an individual to contact in an emergency, by signature below I give my permission for dentist or any member of dentist's staff to release to the identified individual any information which may be required for patient's care. I will not hold dentist or any member of dentist's staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Responsible Party, if "Patient" Above

Signature of Responsible Party, if not "Patient" Above

Date

Front Office Verification

Signature of Treating Dentist

Signature of Hygienist, if Applicable