Hanson Family Dentistry
61 East 96th Street
Indianapolis, IN 46240-1006

(317)721-1552

donaldhansondds.com

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

If Child, Name of Parent or Legal Guardian:

Occupation and Employer:

Emergency Contact & Phone #

Who may we thank for referring you to our office?

Are you currently under the care of a doctor?

◯ Yes ◯ No

Reason:

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Please list any medications you are currently taking, including over the counter supplements:

*

Please list any allergies to Medications or Latex:

*

Do you have or have you ever had any of the following?

- [ ] AIDS/HIV Positive
- [ ] Alzheimer's Disease
- [ ] Anaphylaxis
- [ ] Anemia
- [ ] Angina
- [ ] Arthritis/Gout
- [ ] Artificial Heart Valve
- [ ] Artificial Joint
- [ ] Asthma
- [ ] Blood Disease
- [ ] Blood Transfusion
- [ ] Breathing Problems
- [ ] Cancer
- [ ] Cold Sores/Fever Blisters
- [ ] Diabetes
- [ ] Drug or Alcohol Addiction
- [ ] Emphysema
- [ ] Epilepsy Or Seizures
- [ ] Fainting
- [ ] Allergies/Hay Fever
- [ ] Heart Attack
- [ ] Heart Murmur
- [ ] Heart Pace Maker
- [ ] Heart Trouble/Disease
- [ ] Hepatitis A, B or C
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] Hives or Rash
- [ ] Hypoglycemia
- [ ] Irregular Heartbeat
- [ ] Kidney Problems
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Lung Disesae
- [ ] Mitral Valve Prolapse
- [ ] Parathyroid Disease
- [ ] Psychiatric Care
- [ ] Radiation Treatment
- [ ] Renal Dialysis
- [ ] Rheumatic Fever
- [ ] Scarlet Fever
- [ ] Shingles
- [ ] Sickle Cell Disease
- [ ] Sinus Trouble
- [ ] Stomach/Instestinal Disease
- [ ] Stroke
- [ ] Swelling of Limbs
- [ ] Thyroid Disease
- [ ] Tonsillitis
- [ ] Tuberculosis
- [ ] Tumors or Growths
- [ ] Ulcers
- [ ] Venereal Disease
- [ ] Yellow Jaundice

Other:

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Please list any surgeries or hospitalizations and dates:

Please tobacco history, type, frequency and for how many years:

Women:

- ◯ Are you pregnant?
- ◯ Nursing?
- ◯ Taking Oral Contraceptives?

Date of last Dental Visit and Dental Xrays:

Reason for leaving previous Dentist:

Check any that apply:

- ☐ Sensitive teeth
- ☐ Jaw pain, TMJ or joint pain
- ☐ Interest in straighter teeth
- ☐ Interest in whiter teeth

Is there anything about your smile you would like to change?

☐ To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete informtion can be dagngerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical or dental status.

SIGNAURE OF PATIENT, PARENT or GUARDIAN

Signature: _____

Date: *

Response Date: