DR. NEIL HOSS, DMD, LLC

PATIENT REGISTRATION & HEALTH HISTORY

PATIENT INFORMATION

Last name: _____ First name: _____ MI: _____

Date of birth: _____ Cell phone: _____ Home: _____

Work phone: _____ Email: _____

Street address: _____ Apt: _____

City: _____ State: _____ ZIP: _____

Referred by: _____ SSN (if required): _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's name (if applicable): _____

RESPONSIBLE PARTY (IF PATIENT IS UNDER 18)

Person responsible for payment: _____

Relationship to patient: _____

DENTAL INSURANCE

Policyholder: _____ Date of birth: _____

Policyholder SSN: _____ Insurance company: _____

Member/ID number: _____ Group number: _____

Employer: _____ Occupation: _____

Insurance company claims address: _____

CONSENT, INSURANCE ASSIGNMENT & PRIVACY ACKNOWLEDGMENT

Appointments: Please provide at least 24 hours' notice if you cannot attend. A $75 fee may be charged for missed appointments.

I authorize payment of dental insurance benefits to Dr. Neil Hoss. I understand the office may submit claims as a courtesy; my insurance policy is between my insurer and me. I remain responsible for payment for services rendered, due at the time of service. I understand the practice does not participate with all insurance plans.

I authorize appointment reminders by text and phone. I acknowledge receipt of the Notice of Privacy Practices.

Printed name: _____ Signature: _____

Date: _____

MEDICAL HISTORY

Please check Yes or No for each condition, whether past or current. Include medications and treatments that may affect dental care.

Current medications (including injections and supplements): _____

_____

Allergies and reactions: _____

Emergency contact: _____ Phone: _____

Relationship: _____ Physician: _____

Physician town / phone:

_____

Pharmacy / town / phone:

_____

Specialist physicians (e.g., cardiologist, oncologist): _____

Have you ever taken bone-loss prevention medication (Fosamax, Actonel, Boniva, etc.)? ☐ Yes ☐ No

Have you been advised to take antibiotics or other premedication before dental care? ☐ Yes ☐ No

Have you been hospitalized in the past five years? ☐ Yes ☐ No

HEALTH CONDITIONS AND HISTORY

Heart disease / heart attack ☐ Y ☐ N

Congenital heart disease ☐ Y ☐ N

High blood pressure ☐ Y ☐ N

Artificial heart valve ☐ Y ☐ N

Rheumatic fever ☐ Y ☐ N

Cortisone medication ☐ Y ☐ N

Stroke ☐ Y ☐ N

Artificial joints ☐ Y ☐ N

Diabetes ☐ Y ☐ N

Cancer ☐ Y ☐ N

Tuberculosis ☐ Y ☐ N

Cold sores ☐ Y ☐ N

High cholesterol ☐ Y ☐ N

Sleep apnea ☐ Y ☐ N

Chemotherapy ☐ Y ☐ N

Anemia ☐ Y ☐ N

Neurological disorders ☐ Y ☐ N

Bruise easily ☐ Y ☐ N

Hemophilia ☐ Y ☐ N

Slow healing ☐ Y ☐ N

Frequent headaches ☐ Y ☐ N

Latex sensitivity ☐ Y ☐ N

Vaping / e-cigarette use ☐ Y ☐ N

Chest pain ☐ Y ☐ N

Heart murmur ☐ Y ☐ N

Low blood pressure ☐ Y ☐ N

Pacemaker ☐ Y ☐ N

Arthritis / rheumatism ☐ Y ☐ N

Swollen ankles ☐ Y ☐ N

Special / restricted diet ☐ Y ☐ N

Kidney problems ☐ Y ☐ N

Thyroid problems ☐ Y ☐ N

Epilepsy / seizures ☐ Y ☐ N

HIV / AIDS ☐ Y ☐ N

Hepatitis ☐ Y ☐ N

Major surgery ☐ Y ☐ N

Radiation therapy ☐ Y ☐ N

Liver disease ☐ Y ☐ N

Sexually transmitted infection ☐ Y ☐ N

Psychiatric treatment ☐ Y ☐ N

Blood transfusions ☐ Y ☐ N

Dizzy spells ☐ Y ☐ N

Prolonged bleeding ☐ Y ☐ N

Shortness of breath ☐ Y ☐ N

Acid reflux / GERD (GURD) ☐ Y ☐ N

GLP-1 medication use (e.g., Ozempic, Wegovy, Mounjaro) ☐ Y ☐ N

ADDITIONAL MEDICAL QUESTIONS

Any diseases, conditions, or health concerns not listed above? ☐ Yes ☐ No

If yes, please describe: _____

For patients who could be pregnant:

Are you pregnant or do you think you may be pregnant? ☐ Yes ☐ No

GLP-1 medication name, dose and last dose (if applicable): _____

DENTAL HISTORY

Reason for today's visit: _____

Date of last dental visit: _____

Treatment performed at last visit: _____

How often do you brush? _____ How often do you floss? _____

Do you currently use or have you previously used tobacco products? ☐ Yes ☐ No

If yes, type (including vaping): _____

Current dental concerns: _____

DENTAL SYMPTOMS & EXPERIENCES

Sensitivity to hot or cold ☐ Y ☐ N

Pain when biting or chewing ☐ Y ☐ N

Cold sores ☐ Y ☐ N

Family history of gum disease or tooth loss ☐ Y ☐ N

Orthodontic treatment ☐ Y ☐ N

Periodontal treatment ☐ Y ☐ N

Bite plate or mouth guard ☐ Y ☐ N

Clenching or grinding teeth ☐ Y ☐ N

Tired jaws in the morning ☐ Y ☐ N

Jaw clicking or popping ☐ Y ☐ N

Difficulty opening or closing mouth ☐ Y ☐ N

Satisfied with appearance of teeth ☐ Y ☐ N

Sensitivity to sweets ☐ Y ☐ N

Mouth odor or bad taste ☐ Y ☐ N

Bleeding or painful gums ☐ Y ☐ N

Loose teeth or change in bite ☐ Y ☐ N

Oral surgery ☐ Y ☐ N

Teeth grinding / bite adjustment ☐ Y ☐ N

Serious mouth or head injury ☐ Y ☐ N

Mouth breathing ☐ Y ☐ N

Snoring or other sleep disorders ☐ Y ☐ N

Jaw, tooth or facial pain ☐ Y ☐ N

Difficulty chewing on either side ☐ Y ☐ N

Nervous about dental treatment ☐ Y ☐ N

If serious injury, where / when: _____

I confirm that the information provided is accurate to the best of my knowledge.

Patient / guardian signature: _____ Date: _____