HOOPER ENDODONTICS

1401 Fountain Park Circle | Brunswick, Georgia 31520
912.265.0001 | www.hooperendo.com

Jason T. Hooper, DMD

PATIENT REGISTRATION AND HEALTH HISTORY FORM

Title ☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Other_____

Name _____
First name Middle initial Last name

Address _____
Street City State ZIP

Gender ☐F ☐M Date of Birth ____/____/____ Social Security no._____

Home phone no. _____ Work or cell no. _____

Discomfort ☐None ☐Slight ☐Moderate ☐Severe

General dentist _____ Referred by _____
First and last name Write 'same' if referred by general dentist

Emergency contact _____ Phone no. _____

Please fill out the following health history to the best of your knowledge. All patient information is confidential. Although endodontists primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the care that you will be receiving. Your answers are for our records only and are confidential.

Do you have any health conditions of which the doctor should be aware? ○ Yes ○ No

Were there any changes in your general health in the past year? ○ Yes ○ No

Are you under the care of a physician? ○ Yes ○ No
If so, for what are you being treated? _____

Date of last medical examination _____

Have you had any illness, surgery or been hospitalized in the past five years? ○ Yes ○ No

Do you have any unhealed injuries, inflamed areas, growths in or around your mouth? ○ Yes ○ No
If so, describe where _____

Do you have a prosthetic joint? ○ Yes ○ No
If so, describe where and when it was placed (month/year) _____

Do you have a heart valve replacement or congenital heart defect? ○ Yes ○ No

(over)

Have you had, or do you currently have, any of the following? Please circle yes or no.

Damaged heart valves/mitral valve prolapse	Yes No	Difficulty breathing or other lung trouble	Yes No
Heart Murmur	Yes No	Blood disorders such as anemia	Yes No
Rheumatic Fever, Rheumatic Heart Disease (RHD)	Yes No	Bruise easily	Yes No
High Blood Pressure or Low Blood Pressure	Yes No	Jaundice/Hepatitis/Liver disease	Yes No
Chest pain, Angina	Yes No	Stomach ulcers/irritable bowel disorder	Yes No
Stroke	Yes No	Sexually transmitted diseases	Yes No
Thyroid trouble	Yes No	Immune system problems	Yes No
Diabetes / Low Blood Sugar	Yes No	Delay in healing	Yes No
Kidney trouble, dialysis	Yes No	Tumor or growth	Yes No
Heart attack	Yes No	X-ray treatment or chemotherapy	Yes No
Irregular heart beat	Yes No	Eye disease/Glaucoma	Yes No
Cardiac Pacemaker	Yes No	Convulsions/Epilepsy	Yes No
Heart Surgery	Yes No	Malignant hyperthermia	Yes No
Bronchitis, chronic cough	Yes No	History of drug abuse (cocaine, marijuana etc.)	Yes No
Asthma	Yes No	Do you smoke?	Yes No
Hay fever/sinus problems	Yes No	Osteoporosis or have taken bone medication?	Yes No
Tuberculosis	Yes No	Pain and/or clicking of jaw when eating/TMD/TMJ	Yes No
Emphysema	Yes No		

MEDICATION Please list all medicine, drugs, pills, over-the-counter medications you are taking:

_____

_____

_____

ALLERGIES Are you allergic to or had a reaction to any of the following? Please circle yes or no.

Local anesthetics (novocaine, lidocaine, etc.) Yes No

Penicillin Yes No

Other antibiotics Yes No

Please list any other allergies (medicines or otherwise) _____

WOMEN

Are you pregnant? Yes No If so, estimated delivery date _____

Are you nursing? Yes No

Please note that any antibiotics, such as penicillin, may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

ALL PATIENTS

Is there any condition concerning your health about which the doctor should be told? Yes No

Do you wish to speak to the doctor privately about anything? Yes No

OUR PRIVACY POLICY

Your personal privacy is important to our office; we can provide you with our comprehensive 'Notice of Privacy Practices' if you request. By signing below you authorize our office to use your protected personal information, which includes the chart data, x-rays and any forms for the proper diagnosis and treatment of your condition, and for billing of insurance, if applicable. The authorization remains in effect as long as treatment services are rendered to you. You may inspect this information, revoke this authorization in writing, or refuse the authorization by not signing below.

_____ _____ _____

Patient signature Date Dr.