PERSONAL INFORMATION - ADULT DR. ED HOBEN

The following information is required to enable us to provide you with the best possible dental care. Please fill in the entire form. All information is strictly private, and is protected by doctor-patient confidentiality.

If necessary, please do not hesitate to ask the receptionist for assistance in completing this form.

NAME: MR. _____
Last Name First Name

DATE OF BIRTH (DAY/MO/YEAR): _____ MALE ☐ FEMALE ☐ OTHER ☐

RES. TELEPHONE # _____ Cell # _____

ADDRESS _____
Street City Province Postal Code

EMAIL ADDRESS _____

PREFERRED METHOD OF CONTACT (Check One): HOME # ☐ CELL ☐ EMAIL ☐

OCCUPATION _____ EMPLOYER _____

BUSINESS TELEPHONE # _____ MAY WE CONTACT YOU AT WORK? ☐ YES ☐ NO

SPOUSE'S NAME _____EMPLOYER _____

DENTAL INSURANCE? YES ☐ NO ☐ NAME OF INSURANCE COMAPNY_____

NAME OF POLICY HOLDER : _____DATE OF BIRTH_____

GROUP/POLICY #_____ID/SUBSCRIBER#_____

REFERRED BY:_____

DENTAL HISTORY

1. When was your last dental visit? _____ Reason for visit _____

2. Did you have any x-rays at your last visit? ☐ YES ☐ NO ☐ NOT SURE

3. Are you having any dental discomfort or pain and/or what is your chief concern? If yes, please explain. ☐ YES ☐ NO ☐ NOT SURE

4. Have you ever had any teeth removed? If yes, please explain. ☐ YES ☐ NO ☐ NOT SURE

5. Do you have any teeth that are sensitive to heat, cold, pressure or sweets? If yes, please explain.
☐ YES ☐ NO ☐ NOT SURE

6. Have you ever had any treatment or are you being treated for gum or bone/periodontal disease? If yes, please explain.
☐ YES ☐ NO ☐ NOT SURE

7. Have you ever had an accident, injury or surgery to your mouth or teeth? If yes, please explain.
☐ YES ☐ NO ☐ NOT SURE

8. Do you have any pain in your jaw joints or frequent headaches? If yes, please explain.
☐ YES ☐ NO ☐ NOT SURE

9. Do you have a bad taste in your mouth, or bad breath, even after brushing? If yes, please explain.
☐ YES ☐ NO ☐ NOT SURE

10. Do you have any fears or concerns about having dental treatment? If yes, please explain.
☐ YES ☐ NO ☐ NOT SURE

11. Do you have any habits that may affect your dental health? Please check the categories below that apply:

☐ Smoking ☐ Nail Biting ☐ Grinding/ Clenching Teeth ☐ Lip Cheek Biting

☐ Other

12. Are you satisfied with the appearance of your teeth and smile? If no, please explain.
☐ YES ☐ NO ☐ NOT SURE

13. Please list any additional information you wish to discuss with the dentist.

PATIENT'S CONSENT FOR TREATMENT:

I hereby consent to the dental and oral surgical procedures to be necessary or advisable by the doctor or delegated auxiliaries, including the use of local anesthetic, X-rays, sedation or analgesia as indicated. I accept the responsibility for all fees associated with these procedures.

I understand that appointment times will be reserved for necessary treatment. If I am unable to keep the reserved appointment time, I will give the office adequate notice (at least 48 hours prior). I also understand that I may be charged for the lost time if adequate notice is not given.

DATE_____ SIGNATURE (Print or Type) _____

SIGNATURE (Sign or Docusign) _____