Harry G. Hanna D.D.S.

www.drhanna.com

Family and Cosmetic Dentistry

4198 Washington Road - Suite # 4 McMurray, Pa. 15317

(724) 942 - 4500

Patient Information

Thank you for choosing our practice for your dental needs If you have any questions or concerns do not hesitate to ask for assistance . We will be happy to help.

Date_____ Social Security#_____

Name_____ Birth Date_____

First MI Last

Address_____City_____State_____Zip _____

Home phone#_____ Work phone# _____ Cell phone# _____

Do you prefer to receive calls at: Home Work Either Cell

Are you: Minor Married Divorced Single

Parent's employer_____Occupation_____

Business Address_____City_____State_____ Zip _____

Spouse or parent' s name_____ work place _____ phone_____

City_____ State_____

Whom may we thank for referring you to us?_____

Person to contact in case of an emergency_____ Phone#_____

Responsible Party

Name of person responsible for this account?_____ Relationship to patient _____

Address_____City_____State_____Zip_____

Phone # _____ Cell # _____

Name of employer _____ Work phone #_____

* PLEASE CIRCLE PREFERRED CONTACT PHONE NUMBER *

Insurance Information

Name of insured_____ Relationship to patient _____

Birth Date _____ Social Security #_____ Date employed _____

Name of employer_____ Work phone #_____

Address_____ City_____ State_____ Zip_____

Insurance Co._____ Group # _____ Employer #_____

DO YOU HAVE ADDITIONAL INSURANCE ? NO YES IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient_____

Birth Date_____ Social Security # _____ Date employed _____

Name of employer_____ Work phone #_____

Address_____ City_____ State_____ Zip_____

Insurance Co. _____- Group #_____ Employer#_____

Insurance Address_____ City _____ State_____ Zip_____

How much is your deductible? _____ How much have you used?_____ Max. annual benefit?_____

*** I HAVE READ AND ACKNOWLEDGE RECIEPT OF OUR HIPPA PRIVACY RULE AND CONSENT AGREEMENT.

SIGNATURE _____

Dental History

Name _____ Age_____

Former Dentist _____

Reason for today's visit _____

Date of last exam _____ Date of last dental X-rays _____

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

Please check any of the following conditions that apply to you:

Bad breath	Grinding teeth	Sensitivity to cold/hot
Bleeding gums	Jaw pain	Sensitivity to sweets
Clicking or popping of the jaw	Loose teeth or broken fillings	Sensitivity when biting
Food collection between teeth	Periodontal history	Sores or growths in your mouth

Medical History

Physician _____ Date of last visit _____

Please list all medications you are currently taking : _____

_____

Allergies :_____

(Women) Are you pregnant? Yes No Nursing ? Yes No Taking birth control pills? Yes No

Do you need to PRE-MEDICATE before any dental procedure? Yes No

Do you have a history of the following?
Please circle any that apply

AIDS	Cortisone Treatments	Hepatitis	Respiratory Disease
Anemia	Cough, Persistent	High Blood Pressure	Rheumatic Fever
Arthritis, Rheumatism	Cough up blood	HIV Positive	Scarlet Fever
Artificial Heart Valves	Diabetes	HPV	Shortness of Breath
Artificial Joints	Epilepsy	Kidney Disease	Skin Rash
Asthma	Fainting	Latex Allergy	Stroke
Back Problems	Glaucoma	Liver Disease	Swelling of Feet/ Ankles
Blood Disease	Headaches	Mitral Valve Prolapse	Thyroid Problems
Cancer	Heart Murmur	Nervous Problems	Tobacco Habit
Chemical Dependency	Heart Problems	Pacemaker	Tonsillitis
Chemotherapy	Describe_____	Psychiatric Care	Tuberculosis
Circulatory Problems	Hemophilia	Radiation Treatment	Ulcer
			Venereal Disease

Surgeries (last 2 years)_____

Authorization

I certify that I have read and understand the above information to the best of my knowledge.
The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and / or health practitioners.
I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits.
I understand that my dental insurance carrier may pay less than the actual bill for services.
I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Date_____

SIGNITURE OF PATIENT (Or parent if a minor)