MARC J HOLLANDER
DDS & ASSOCIATES

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Gahanna, OH 43230
(614) 344-6844

PATIENT INFORMATION

We would like to take this opportunity to welcome you to our dental practice. In order to make your visits as pleasant and comfortable as possible, we would appreciate it if you would fill out this patient questionnaire and medical history. Please release and fill this out as accurately as possible. Thank you.

NAME _____ DATE _____

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED (CHECK ONE)

ADDRESS _____ CITY _____ ZIP _____

E-MAIL/HOME _____ E-MAIL/OFFICE _____ FAX # _____

PREVIOUS ADDRESS _____ HOME PHONE # _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____ CELL # _____

EMPLOYER _____ WORK PHONE # _____

SPOUSE/SIGNIFICANT OTHER _____ SPOUSE'S EMPLOYER _____ WORK PHONE # _____

EMERGENCY CONTACT _____ PHONE # _____

PERSON RESPONSIBLE FOR ACCOUNT: ☐ SELF ☐ OTHER: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? _____

DENTAL INSURANCE QUESTIONNAIRE

DENTAL INSURANCE INFORMATION

EMPLOYEE NAME _____

DATE OF BIRTH _____

SOCIAL SECURITY # _____

EMPLOYER _____

ADDRESS _____

INSURANCE COMPANY _____

YOUR RELATIONSHIP TO THE INSURED (CHECK ONE):

☐SELF ☐SPOUSE ☐CHILD ☐PARENT ☐OTHER

DENTAL INSURANCE INFORMATION

EMPLOYEE NAME _____

DATE OF BIRTH _____

SOCIAL SECURITY # _____

EMPLOYER _____

ADDRESS _____

INSURANCE COMPANY _____

YOUR RELATIONSHIP TO THE INSURED (CHECK ONE):

☐SELF ☐SPOUSE ☐CHILD ☐PARENT ☐OTHER

IF YOU HAVE DOUBLE INSURANCE COVERAGE, BE SURE TO COMPLETE BOTH SECTIONS

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

By Federal Law, we are required to have you sign the following, if we are to extend credit:

I/We give the above information for the purpose of obtaining credit and authorize you to obtain further information concerning any statement made from any source. I/We agree that all credit will be governed by this Financial agreement and Initial Disclosure Statement, and if more than one signature appears below, will be our joint and several obligation.

Applicant's signature _____

Co-applicant's signature (for joint accounts only): _____

Federal Equal Credit Opportunity act prohibits creditors from discriminating against credit application on the basis of sex or marital status. The federal agency which administers compliance with this office is the Federal Trade Commission.

DENTAL AND MEDICAL HISTORIES

DOES YOUR HOME CARE INCLUDE (PLEASE CHECK): ☐ BRUSH ☐ FLOSS ☐ WATERJET ☐ FLOURIDES

WHO IS YOUR REGULAR PHYSICIAN? _____

1. Are you having dental pain or discomfort at this time? ☐ Yes ☐ No
2. Do you feel overly nervous about having dental treatment? ☐ Yes ☐ No
3. Have you ever had a bad experience in the dental office? ☐ Yes ☐ No
4. Have you been a patient in the hospital during the past two years? ☐ Yes ☐ No
5. Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No
6. Have you taken any medicine or drugs during the past two years? ☐ Yes ☐ No
7. Are you allergic to (itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, latex products or any drugs or medications? ☐ Yes ☐ No
8. Have you ever had any excessive bleeding requiring special treatment? ☐ Yes ☐ No
9. Check any of the following which you have had or currently have:

☐ Acid Reflux	☐ Cold Sores	☐ Heart Surgery	☐ Rheumatic Fever
☐ AIDS/HIV	☐ Congenital Heart Problems	☐ Hemophilia	☐ Scarlet Fever
☐ Allergies or Hives	☐ Cortisone Medicine	☐ Hepatitis A (Infectious)	☐ Sinus Trouble
☐ Anemia	☐ CPAP Device	☐ Hepatitis B (Serum)	☐ Sleep Apnea
☐ Angina Pectoris	☐ Diabetes	☐ Herpes	☐ Stoke
☐ Artificial Heart Valve	☐ Epilepsy or Seizure	☐ High Blood Pressure	☐ Substance Abuse
☐ Artificial Joint	☐ Fainting or Dizzy Spells	☐ Kidney Trouble	☐ Thyroid Disease
☐ Arthritis	☐ Frequent Coughs	☐ Liver Disease	☐ Tuberculosis (TB)
☐ Asthma	☐ Glaucoma	☐ Lung Disease	☐ Ulcers
☐ Blood Transfusion	☐ Heart Disease	☐ Mitral Valve Prolapse	☐ Venereal Disease
☐ Bruise Easily	☐ Heart Murmur	☐ Osteoporosis/Penia	☐ Yellow Jaundice
☐ Chemotherapy/Radiation	☐ Heart Pacemaker	☐ Pain in Jaw Joints	

10. Medicines you are currently taking? _____
11. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ☐ Yes ☐ No
12. Do your ankles swell during the day? ☐ Yes ☐ No
13. Do you ever wake up from shortness of breath when sleeping? ☐ Yes ☐ No
14. Are you on a special diet? If yes, explain: _____ ☐ Yes ☐ No
15. Has your medical doctor ever said you have cancer or a tumor? ☐ Yes ☐ No
16. Women: Are you pregnant now? ☐ Yes ☐ No
17. Do you have any disease, condition, or problem not listed? Describe: _____ ☐ Yes ☐ No
18. Do you wish to talk to the doctor about any problems not listed? ☐ Yes ☐ No
19. Do you use tobacco products? (Check one) ☐ CIGARETTES ☐ SMOKELESS ☐ OTHER

AUTHORIZATION

I hereby authorize Dr. Marc J. Hollander to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and Medical History Form are correct to the best of my knowledge.

Signature: _____ Date: _____

☐ Self ☐ Parent ☐ Guardian

Reviewed by: Dr. _____ Date: _____