



# Pennington Family Dentistry

Creating generations of smiles since 1962

**Bernard L. Hoffman, III, DDS**

*Implant & Restorative Dentistry*

**A FINANCE FEE WILL BE APPLIED MONTHLY IF ACCOUNT IS OVER 90 DAYS PAYMENT IS DUE THE DAY SERVICES ARE RENDERED**

**Ana Paula Hoffman, DDS, MSc, PhD**

*Cosmetic & Pediatric Dentistry*

Comprehensive, One-Stop Care

- Complete implant dentistry
- Cosmetic dentistry (veneers, whitening)
- Restorative dentistry with dental crowns and dental bridges
- Sleep appliances to reduce or eliminate snoring and sleep apnea
- Preventive dentistry to help you keep your own teeth for life
- Pediatric dentistry focused on children age 3 and up
- Root canal therapy
- Invisalign®
- Nitrous oxide

Patient Comfort & Convenience

- Most insurances accepted and filed for you
- Flexible and no-interest payment plans, CareCredit®, autopay
- Visa, MasterCard, Discover accepted
- Conveniently located with ample free parking
- Office hours: Mon–Thu, 8am–7:30pm; Fri, 8am–5pm
- Appointments seen promptly, no waiting
- Same-day emergency appointments
- Morning, afternoon and evening appointments

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Email: \_\_\_\_\_ Employer: \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Widow \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_

Person Responsible For Account: \_\_\_\_\_

Address (IF DIFFERENT FROM ABOVE) \_\_\_\_\_ Referred By: \_\_\_\_\_

Dental Insurance: \_\_\_\_\_ Name of Subscriber: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of Last Exam: \_\_\_\_\_ Last Dental Exam: \_\_\_\_\_

Are you currently under medical treatment: \_\_\_\_\_ If yes, Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you been hospitalized for surgeries or serious illness in the last 5 years? \_\_\_\_\_

If yes, Explain: \_\_\_\_\_

Are you taking any medication(s) including non-prescription medicine? \_\_\_\_\_



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List all medications: \_\_\_\_\_

	YES	NO
Do you take a baby aspirin?	_____	_____
Do you use tobacco?	_____	_____

Are you allergic to or have you had any reactions to the following:

Local Anesthetics	_____	_____
Penicillin or any other antibiotics	_____	_____
Sulfa Drugs	_____	_____
Barbiturates	_____	_____
Sedatives	_____	_____
Iodine	_____	_____
Aspirin	_____	_____
Any Metal (nickel, mercury, etc.)	_____	_____
Latex Rubber	_____	_____
Other: _____		

**Women Only:**

Are you pregnant or think you may be pregnant?	_____	_____
Are you nursing?	_____	_____
Are you taking oral contraceptives?	_____	_____

Do you have or have you had any of the following? Circle all that apply:

High Blood Pressure	Fainting/Seizures	Joint Replacement/Implant
Heart Disease	Frequently Tired	Hepatitis
Chest Pains	Anemia	Hay Fever/Allergies
Heart Attack	Mitral Valve Prolapse	Thyroid Problem
Pacemaker	Respiratory Problems	Kidney Disease
Recent Weight Loss	Low Blood Pressure	Stomach Troubles
Rheumatic Fever	Emphysema	Sexually transmitted disease
Heart Murmur	Tuberculosis	Easily Winded
Heart trouble	Leukemia	Cancer
Swollen Ankles	Arthritis	Radiation therapy
Angina	Liver Disease	
Asthma	Diabetes	
Stroke		



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If there are any existing medical conditions NOT listed above, please enter below:

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