

HEALTH HISTORY AND PATIENT INFORMATION

(Please Print)

Married
Single
Widowed
Divorced

Gender

M F

Last Name

First Name

Middle Initial

Address

Street

City

State

Zip

SSN _____ If patient is minor, responsible parent _____

Home/Cell # _____ Business Phone _____

Employed by _____ Occupation _____

Who Referred You? _____ Family Dentist (if different) _____

Family Physician _____ Date of Last Physical _____

Date of Birth _____ Age _____

PLEASE CHECK YES OR NO:

YES NO

- | | | |
|--|--------------------------|--------------------------|
| 1. High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Pacemaker Date Placed _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Heart Condition | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please specify _____ | | |
| 9. Endocarditis | <input type="checkbox"/> | <input type="checkbox"/> |
| (inflammation or infection of the heart) | | |
| 10. Episode of Prolonged Bleeding | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Diabetes Type <input type="checkbox"/> 1 <input type="checkbox"/> 2 | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Thyroid Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Cancer Type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. AIDS/HIV | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. TB/PPD Positive | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Cold Sores or Mouth Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. GI/Intestinal Issues | <input type="checkbox"/> | <input type="checkbox"/> |
| (i.e. Colitis or Clostridium Difficile) | | |
| 21. Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| what trimester _____ | | |

- | | | |
|---------------------------|--------------------------|--------------------------|
| 22. Major Operation | <input type="checkbox"/> | <input type="checkbox"/> |
| List & Date _____ | | |

23. Do you have a prosthetic device?
- heart valve hip knee
- organ transplant other _____
- If so, what is the name of the Doctor who placed the prosthetic device?

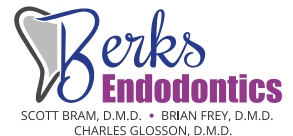
Surgeon Name: _____ Date: _____

- | | | |
|--|--------------------------|--------------------------|
| 24. Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you take oral steroids? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do you take blood thinners? | <input type="checkbox"/> | <input type="checkbox"/> |
| (i.e. Coumadin / Plavix / Aspirin) | | |
| 27. Do you take / have taken Oral or IV bone density medications (i.e. Fosamax / Boniva)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. ALLERGY | | |
| Latex | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa | <input type="checkbox"/> | <input type="checkbox"/> |
| Local Anesthetic | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain Medication (i.e. Codeine) | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Medication Allergies _____ | | |
| 29. Does a <u>physician</u> require you to take antibiotics for premed before dental visits? | <input type="checkbox"/> | <input type="checkbox"/> |
| (i.e. For heart condition, knee or hip replacement) | | |

Name of Antibiotic: _____

1150 Berkshire Blvd, Suite #120, Wyomissing PA 19610

Phone: 610-376-1536 | Fax: 610-376-4241



Please list any medications used and their purpose:

Are you presently under a physician's care? **YES** **NO**

For what specific condition? _____

Name of Physician _____

Date of Last Medical Exam _____

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Are you in discomfort now? _____

2. What causes the discomfort? (circle all that apply) **COLD** **HOT** **CHEWING** **CONSTANT**

3. How long have you had this discomfort? _____

4. Can you pinpoint the tooth causing the problem? _____

5. Have you noticed any swelling in the gums or a "bubble" by the tooth? _____

Do you have dental insurance? **YES** **NO**

If yes . . . Do you have more than one dental insurance? **YES** **NO**

Insurance Company Name(s) _____

Insurance Company Address _____

_____ Telephone # _____

Insured's Name _____ Insured's DOB _____

Insured's Social Security # _____

Insured's Employer _____

Group # _____ Insured's ID # _____

PLEASE READ THE STATEMENT BELOW AND SIGN IN THE SPACE PROVIDED.

PATIENT'S RESPONSIBILITY - I have completed this form and fully certify that all the above information is **true and correct**. I also certify that I am the **patient** (or authorized agent of the patient) **authorized** to furnish all information requested. I understand that even if I have some form of insurance coverage, that I am the person responsible for payment of services rendered. **I am aware that the dentist is a participating doctor with multiple insurance companies.**

Patient's Signature (or Parent if patient is a minor) Date