Dental History

Why have you come to the dentist today? ____________

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Your current dental health is? ❑ Good ❑ Fair ❑ Poor

Do you floss daily? ❑ Yes ❑ No

Brush Daily? ❑ Yes ❑ No

Type of bristles on your toothbrush? ❑ Hard ❑ Med ❑ Soft

Do your gums ever bleed? ❑ Y ❑ N Ever Itch? ❑ Y ❑ N

Have you ever had periodontal disease? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? ____________

Do you have mobility in your teeth? ❑ Yes ❑ No

Do you still have wisdom teeth? ❑ Yes ❑ No

Previous/Present Dentist: ____________
(Please Circle)

Would you like fresher breath? ❑ Yes ❑ No

Whiter Teeth? ❑ Yes ❑ No

Are you happy with the way your smile looks? Yes ❑ No

If not, what would you change? ____________

Medical History

Are you currently under the care of a physician? ❑ Yes ❑ No Doctor: ____________

Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No What/When: ____________

Have you ever had a serious head or neck injury? ❑ Yes ❑ No When: ____________

Are you taking any medications, pills or drugs? ❑ Yes ❑ No List: ____________

Do you take, or have you ever taken, Phen-Fen or Redux? ❑ Yes ❑ No

Are you on a special diet? ❑ Yes ❑ No

Do you use tobacco? ❑ Yes ❑ No

Do you use controlled substances? ❑ Yes ❑ No

Women: Are you ❑ Pregnant/Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics

❑ Other ____________ ❑ No known drug allergies

Do you or have you experienced the following?

❑ AIDS/HIV+
❑ Alzheimer's Disease
❑ Anaphylaxis
❑ Anemia
❑ Angina
❑ Arthritis/Gout
❑ Artificial Heart Valve*
❑ Artificial Joint*
❑ Asthma
❑ Blood Disease
❑ Blood Transfusion
❑ Breathing Problem
❑ Bruise Easily
❑ Cancer
❑ Chemotherapy
❑ Chest Pains
❑ Cold Sores/Fever Blisters
❑ Congenital Heart Defect
❑ Convulsions
❑ Cortisone Medicine
❑ Diabetes
❑ Drug Addiction
❑ Easily Winded
❑ Emphysema
❑ Epilepsy or Seizures
❑ Excessive Bleeding
❑ Excessive Thirst
❑ Faintinng Spells /Dizziness
❑ Frequent Cough
❑ Frequent Diarrhea
❑ Frequent Headaches
❑ Genital Herpes
❑ Glaucoma
❑ Hay Fever
❑ Heart Attack/Failure
❑ Heart Murmur*
❑ Heart Pace Maker*
❑ Heart Trouble/Disease
❑ Hemophilia
❑ Hepatitis A
❑ Hepatitis B or C
❑ Herpes
❑ High Blood Pressure
❑ Hives or Rash
❑ Hypoglycemia
❑ Irregular Heartbeat
❑ Kidey Problems
❑ Leukemia
❑ Liver Disease
❑ Low Blood Pressure
❑ Lung Disease
❑ Mitral Valve Prolapse*
❑ Pain in Jaw Joints
❑ Parathyroid Disease
❑ Psychiatric Care
❑ Radiation Treatments
❑ Recent Weight Loss
❑ Recent Dialysis
❑ Rheumatic Fever*
❑ Rheumatism
❑ Scarlet Fever
❑ Shingle
❑ Sickle Cell Disease
❑ Sinus Trouble
❑ Spinal Bifida
❑ Stomach /Intestinal Disease
❑ Stroke
❑ Swelling of Limbs
❑ Thyroid Disease
❑ Tonsilitis
❑ Tuberculosis (TB)
❑ Tumors or Growths
❑ Ulcers
❑ Venereal Disease
❑ Yellow Jaundice

Have you ever had any serious illness not listed above? ❑ Yes ❑ No ____________

Do you take, or have you taken Bisphosphonates? (Examples: Actonel® Boniva® Fosamax®) ❑ Yes ❑ No

Comments: ____________

*Condition may require medication N/A - Not answered by patient

Our office is HIPAA compliant and is committed to meeting the standards of infection control mandated by OSHA, the CDC and the ADA.

Authorization

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

____________ Signature of Patient, Parent or Guardian ____________ Date

Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

ALLEN DENTAL CENTER, PA

A Family Tradition of Dental Excellence – Guaranteed

About You

Today's Date: ______________ E-mail Address ______________________________

Name: ______________________________ I prefer to be called: ______________ ❑ Male ❑ Female

Last First Mi Mr. Mrs. Ms. Dr.

Birthdate: ___/___/___ Age: __________ Social Security#: ______________

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: ____

Street City State Zip

Home Phone #: (_____)__________ Cell #: (_____)__________

Work Phone #: (_____)__________ Ext: _____ Driver's License #: ______________

Would you be interested in being contacted via email? ❑ Yes ❑ No via texting? ❑ Yes ❑ No

Whom may we thank for referring you? ❑ Allen Image ❑ Allen Family Magazine ❑ Sign ❑ Website ❑ Yellow Pages ❑ Best of Allen

❑ Care Enough to Share Brochure ❑ Patient or staff Member (Name: ______________________________)

Other: ____

Other family member seen by us: ______________________________

Employer: ______________ How long there? __________ Occupation ______________

Employer's Address: ____

Street City State Zip

RESPONSIBLE PARTY

❑ **Check here if the responsible party is the same as above.**

His/Her Name: ______________________________ Relation: ______________

Work Phone #: (_____)__________ Home Phone #: (_____)__________

Social Security#: ______________ Birthdate: ___/___/___ Cell Phone #: (_____) ______________

Address: ____

Street City State Zip

EMERGENCY CONTACT

His/Her Name: ______________________________ Relation: ______________

Phone #: (_____) ______________ Alternate Phone #: (_____)__________

Address: ____

Street City State Zip

Dental Insurance Information

Primary Insurance

Insurance Co. Name: ______________________________ Phone #: (_____) ______________

Group # (plan/Policy): ______________________________

Insurance Co. Address: ____

Street City State Zip

Insured's Name: ______________________________ Insured's Social Security #: ______________

Insured's Birthdate: ___/___/___ Relation: ______________

Insured's Employer: ______________________________ Insured's ID #: ______________