Welcome to the **NEW HOPE - SOLEBURY DENTAL ASSOCIATES** Dentist

1 ABOUT YOU

Today's Date: _____ Age: _____

Name: _____
LAST FIRST MI SALUTATION

I prefer to be called: _____ ☐ MALE ☐ FEMALE

Birthdate: ____/ ____/ ____ SSN: _____ DL #: _____

Home Address: _____
APT/CONDO#

_____
CITY STATE ZIP

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

E-mail Address: _____

Cell #: (_____) _____-_____ Hm #: (_____) _____-_____

Wk #: (_____) _____-_____ Ext: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are the best times to reach you?

_____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

2 SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: (_____) _____-_____ Ext: _____ SSN: _____

Birthdate: ____/ ____/ ____

Person Responsible for Account: _____

Cell #: (_____) _____-_____ Hm #: (_____) _____-_____

Billing Address: _____

Relation: _____ SSN: _____

Employer: _____

Wk #: (_____) _____-_____ Ext: _____

3 DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (_____) _____-_____

Group #: _____ Insured's ID #: _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ____/ ____/ ____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (_____) _____-_____

Group #: _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ____/ ____/ ____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Cell #:(_____) _____-_____ Hm #: (_____) _____-_____

4 MEDICAL HISTORY

Do you have a personal physician? ☐Yes ☐ No

Physician's Name: _____

Wk #: (_____) _____-_____ Date of last visit? _____

Are you under the care of a physician? ☐ Yes ☐ No

Please explain: _____

_____

CONTINUED ON BACK

5 MEDICAL HISTORY *continued*

Your current physical health is: ☐Good ☐Fair ☐Poor

Are you taking any prescription/over-the-counter or supplemental drugs? ☐ Yes ☐ No

Please list each one: _____

Do you smoke or use tobacco, in any form? ☐ Yes ☐ No

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Do you snore or hold your breath in your sleep? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following disease or medical problems? (Please circle Y or N)

Y N Anemia/Radiation Treatment
Y N Artificial Bones/Joint /Valves
Y N Arthritis
Y N Severe/Frequent Headaches
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Hemophilia/Abnormal Bleeding
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema/Glaucoma
Y N Epilepsy/Seizures/Fainting Spells
Y N Fever Blisters/Herpes
Y N Heart Attack/Stroke
Y N Heart Murmur
Y N Heart Surgery/Pacemaker
Y N Diabetes
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV+/AIDS
Y N Ever Hospitalized
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Treatment
Y N Rheumatic/Scarlet Fever
Y N Asthma
Y N Shingles
Y N Sickle Cell Disease/Traits
Y N Sinus Problems
Y N Tuberculosis (TB)
Y N Ulcers/Colitis
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Latex
Y N Erythromycin
Y N Jewelry/Metals
Y N Dental Anesthetics
Y N Penicillin
Y N Tetracycline
Y N Other

6 DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

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

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experience pain / discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristle? ☐ Hard ☐Medium ☐Soft

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ _____
Signature Date

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have questions at this time, please ask us. We are happy to help

Medical History Update

Date: _____ Comments: _____ Signature: _____
Date: _____ Comments: _____ Signature: _____
Date: _____ Comments: _____ Signature: _____
Date: _____ Comments: _____ Signature: _____
Date: _____ Comments: _____ Signature: _____
Date: _____ Comments: _____ Signature: _____

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____