WELCOME TO QUAKERTOWN FAMILY DENTAL CENTER

NAME________________________DOB____________MARITAL STATUS________SS#_____-____-_____

ADDRESS________________________CITY____________________STATE_______ ZIP______

HOME PHONE(____)______________CELL PHONE(____)______________WORK PHONE(____)______________

E-MAIL________________________EMPLOYER________________________

PRIMARY DENTAL INSURANCE____________________SUBSCRIBER____________________

SS#_____-_____-_____ID#__________________DOB____________GROUP #________________

EMPLOYER________________________RELATIONSHIP TO PATIENT________________

SECONDARY DENTAL INSURANCE__________________SUBSCRIBER____________________

SS#_____-_____-_____ID#__________________DOB____________GROUP #________________

EMPLOYER________________________RELATIONSHIP TO PATIENT________________

PERSON RESPONSIBLE FOR DENTAL BILLS____

EMERGENCY CONTACT & RELATIONSHIP______________________PHONE #(____)______________

PATIENT DENTAL HISTORY

LAST DENTAL VISIT____________________LAST DENTAL CLEANING____________________

PREVIOUS DENTIST________________________ADDRESS________________________

CITY____________________STATE_____ZIP________PHONE #________________________

HAVE YOU HAD DENTAL X-RAYS Y N PANOREX OR FULL MOUTH Y N BITEWINGS Y N

HOW OFTEN DO YOU BRUSH YOU TEETH?______________HOW OFTEN DO YOU FLOSS?________________

YES	NO	
____	____	HAVE YOU HAD BROKEN TEETH/ FILLINGS?
____	____	IF SO, WERE THEY REPAIRED?
____	____	HAVE YOU HAD TEETH EXTRACTED?
____	____	IF SO, WERE THERE COMPLICATIONS?
____	____	WERE MISSING TEETH REPLACED?
____	____	IF SO, BY PARTIALS OR DENTURES
____	____	BY BRIDGES
____	____	BY IMPLANTS
____	____	WOULD YOU LIKE MISSING TEETH REPLACED?
____	____	DO YOU HAVE PAIN IN OR AROUND YOUR EARS?
____	____	ARE YOU UNHAPPY WITH YOUR TEETH? (SHAPE,COLOR,ALIGNMENT) IF SO, WHAT WOULD YOU LIKE TO CHANGE?________________ ________________________

YES	NO	
____	____	HAVE YOU HEARD OF DENTAL IMPLANTS
____	____	WOULD YOU LIKE MORE INFORMATION ON DENTAL IMPLANTS?
____	____	DO YOUR GUMS BLEED?
____	____	DO YOU FEEL YOU HAVE BAD BREATH OR AN UNPLEASANT TASTE?
____	____	HAVE YOU HAD PERIODONTAL (GUM) TREATMENT?
____	____	DO YOU GRIND/CLENCH YOUR TEETH
____	____	DO YOU HEAR POPPING/CLICKING IN YOUR JAW?
____	____	HAVE YOU BEEN DIAGNOSED WITH TMJ DISORDER?
____	____	DO YOU HAVE ANY UNTREATED INJURIES, GROWTHS, OR SORE SPOTS IN YOUR MOUTH?

(FILL OUT OTHER SIDE PLEASE)

PATIENT MEDICAL HISTORY

YES	NO	
____	____	ARE YOU CURRENTLY IN GOOD HEALTH?
____	____	HAVE YOU HAD ANY MAJOR OPERATIONS? IF SO, WHAT________________________________
		____
____	____	HAVE YOU HAD ANY INJURIES INVOLVING YOUR HEAD OR JAWS?
____	____	HAVE YOU HAD ANY ADVERSE REACTION TO DRUGS INCLUDING PENICILLIN AND ASPIRIN? IF SO, PLEASE LIST________________________________
		____

HAVE YOU EVER HAD ANY OF THE FOLLOWING (PLEASE CHECK ANY THAT APPLY):

____ HEART AILMENT, MURMUR, SURGERY
____ HIGH BLOOD PRESSURE
____ LOW BLOOD PRESSURE
____ RESPIRATORY DISEASE
____ DIABETES
____ RHEUMATIC/SCARLET FEVER
____ TUMOR/GROWTHS
____ USE OF TOBACCO/E-CIGARETTES
____ BLOOD DISEASE
____ LIVER DISEASE
____ KIDNEY DISEASE
____ STOMACH/INTESTINAL DISEASE
____ VENEREAL DISEASE
____ YELLOW JAUNDICE/HEPATITIS
____ EPILEPSY
____ AIDS/HIV+
____ RADIATION.COBALT TREATMENT
____ GLAUCOMA
____ CHEMOTHERAPY
____ THYROID DISEASE
____ PSYCHIATRIC THERAPY

YES	NO	
____	____	ARE YOU CURRENTLY ON A DIET?
____	____	ARE YOU PREGNANT? DUE DATE_____
____	____	DO YOU SNORE HEAVILY AT NIGHT?
____	____	ARE YOU TIRED DURING THE DAY?
____	____	DO YOU HAVE A HISTORY OF FAINTING?
____	____	DO YOU HAVE A PACEMAKER
____	____	DO YOU SLEEP WELL AT NIGHT?
____	____	ARE YOU ALLERGIC TO ANY KNOWN MATERIALS RESULTING IN HIVES, ASTHMA, ECZEMA, ETC.? IF SO, WHAT________________________________
		____
____	____	HAVE YOU RECEIVED ANY DONOR ORGANS, ARTIFICIAL HEART VALVES, VESSELS, JOINT IMPLANTS?
____	____	ARE YOU CURRENTLY TAKING ANY MEDICATIONS? IF SO, PLEASE LIST

MEDICATION	REASON
________________	________________________
________________	________________________
________________	________________________

NAME OF MEDICAL DOCTOR/GROUP________________________PHONE#(____)__________

I CERTIFY THAT THE ANSWERS GIVEN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND (IF APPLICABLE) GIVE MY PERMISSION FOR MY INSURANCE COMPANY TO SEND PAYMENTS DIRECTLY TO QUAKERTOWN FAMILY DENTAL CENTER.

____ SIGNATURE

____________________ DATE