MEDICAL HISTORY: Doctor's Signature.
83 Llanfair Circle
Ardmore, PA 19003
Phone: (610)-642-2550

Patient Registration

Patient Information

Patient:_____ Marital Status:_____
First name MI Last name

Date of Birth:(MM/DD/YYYY):_____/_____/_____ Age:_____ Sex: Male/Female: _____

Social Security Number:_____-_____-_____ Occupation:_____

Home Address:_____ Apt#_____

City:_____ State:_____ Zip:_____

Home Phone: ( )- - Cell Phone: ( )- -

Email Address:_____

Emergency Contact: _____ Phone: ( )- -
First name MI. Last name

Whom may we thank for referring you to our office?_____

Primary Insurance Information

Insurance Company:_____ Insurance Company Phone#: ( )- -

Group#:_____ ID#: _____

Employer:_____

Patient's relation to insured (Circle): Self Spouse Child Parent

Subscriber:_____
First name MI. Last name

Subscriber's Date of Birth:(MM/DD/YYYY):_____/_____/_____

Subscriber's Social Security Number#:_____-_____-_____

Secondary Insurance Information

Insurance Company:_____ Insurance Company Phone#: ( )- -

Group#:_____ ID#: _____

Employer:_____

Patient's relation to insured (Circle): Self Spouse Child Parent

Subscriber:_____
First name MI. Last name

Subscriber's Date of Birth:(MM/DD/YYYY):_____/_____/_____

Subscriber's Social Security Number#:_____-_____-_____

Agreement and Consent

I understand that financial arrangements must be determined in advance before treatment. In consideration of the professional services rendered to me, or at my request, by the Doctor and/or her Staff. I agree to pay, therefore, the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof.

I hereby authorize the Doctor and/or her Staff to perform the necessary dental services with my informed consent that I may need during diagnosis and treatment. I am aware that there are some risks inherent in some dental procedures (for example: possible allergic reaction to anesthetic or drug, possible accidental cuts or abrasions). I understand I am free to ask any questions regarding the procedure and risk involved.

_____	_____	_____	_____
Print Name	**Patient / Parent/ Guardian**	**Signature**	**Date**

MEDICAL HISTORY: Doctor's Signature. **Date**

	YES	NO	
1	☐	☐	Are you in good health?
2	☐	☐	Are you under the care of a physician?
			If so, please give physician's name_____ Physician's phone #_____
3	☐	☐	Have you ever been hospitalized or had a serious illness?
	☐	☐	If yes, please explain_____
4	☐	☐	Have you ever been pre-medicated for your dental treatment?

5 Are you taking any of the following?

YES	NO		YES	NO	
☐	☐	Antibiotics	☐	☐	Analgesics (Pain Relievers)
☐	☐	Anticoagulants (Blood Thinners)	☐	☐	Tranquilizers (Valium)
☐	☐	Blood Pressure Medications	☐	☐	Insulin (Diabetes Drugs)
☐	☐	Cortisone (Steroids)	☐	☐	Nitroglycerin (Heart Medications)
☐	☐	Antihistamines (Allergy Drugs)	☐	☐	Dilantin
☐	☐	Cold Remedies	☐	☐	Other:

6 Do you have or have you ever had any of the following?

☐	☐	Chest Pain/Discomfort	☐	☐	Persistent Fever
☐	☐	High Blood Pressure	☐	☐	Persistent Swollen Glands in Neck
☐	☐	Heart Attack/Trouble	☐	☐	Marked Weight Change
☐	☐	Heart Murmur	☐	☐	Chicken Pox/Shingles
☐	☐	Congenital Heart Disease	☐	☐	Mumps
☐	☐	Rheumatic Fever	☐	☐	Herpes
☐	☐	Mitral Valve Prolapse	☐	☐	Scarlet Fever
☐	☐	Artificial Heart Valves	☐	☐	Hives/Rash
☐	☐	Pacemaker	☐	☐	Immune System Disorder (e.g. Lupus)
☐	☐	Angina Pectoris	☐	☐	Venereal Disease (e.g. Syphilis, Gonorrhea)
☐	☐	Heart Surgery	☐	☐	Goiter
☐	☐	Anemia/Sickle Cell Anemia	☐	☐	Thyroid Condition
☐	☐	Hemophilia	☐	☐	Diabetes
☐	☐	Hx. Of Blood Transfusion	☐	☐	Asthma
☐	☐	Arthritis/Rheumatism	☐	☐	Emphysema
☐	☐	Artificial Joints or Limbs	☐	☐	Respiratory Condition
☐	☐	Hepatitis/Liver Disease	☐	☐	Sinus Trouble
☐	☐	Jaundice/Cirrhosis	☐	☐	Persistent Cough
☐	☐	Stomach Ulcers/Gastritis/Colitis	☐	☐	Tuberculosis
☐	☐	Kidney Disease	☐	☐	Radiation Therapy
☐	☐	Renal Dialysis	☐	☐	Chemotherapy
☐	☐	Epilepsy/Seizures/Convulsions	☐	☐	Cancer
☐	☐	Cerebral Palsy	☐	☐	Tumor/Growth
☐	☐	Mental Disorder	☐	☐	HIV/AIDS
☐	☐	Nervous Disorder	☐	☐	Alcohol/Drug Dependency
☐	☐	Psychiatric Treatment	☐	☐	Smoking Habit
☐	☐	Cosmetic Surgery	☐	☐	Other:

7 Are you allergic or have you ever had a reaction to:

☐	☐	Local Anesthetics (e.g. Novocain)	☐	☐	Aspirin
☐	☐	Penicillin/Erythromycin	☐	☐	Sulfa Drugs
☐	☐	Codeine	☐	☐	Barbiturates/Sedatives/Sleeping Pills
☐	☐	Iodine	☐	☐	Latex

WOMEN:

☐	☐	Are you pregnant?	☐	☐	Are you nursing?
☐	☐	Are you taking birth control pills?			

DENTAL HISTORY

1 Why are you seeking dental treatment?_____

2 Does dental treatment make you nervous? (circle) No Slightly Moderately Extremely

3 Date of last visit to a dentist:_____ Date of last full mouth x-rays:_____

	YES	NO
4 Are you wearing a removable dental appliance?	☐	☐
5 Are you unhappy with the appearance of your teeth?	☐	☐
6 Would you like your smile to look better or different?	☐	☐

7 Do you have or have you ever had any of the following?

Orthodontic (Braces) Treatment	☐	☐	Difficulty Opening/Closing Mouth	☐	☐	
Periodontal (Gum) Treatment	☐	☐	Clicking/Popping Jaw	☐	☐	
Frequent Canker Sores/Fever Blisters	☐	☐	Cheek/Lip Biting	☐	☐	
Burning Tongue/Lips	☐	☐	Nail Biting	☐	☐	
Bad Breath/Unpleasant Taste	☐	☐	Finger Sucking	☐	☐	
Swelling or Lumps in Mouth	☐	☐	Clenching/Grinding	☐	☐	
Sensitive Teeth to Cold/Hot/Sweets/Biting	☐	☐	Food Impaction	☐	☐	
Shifting of Teeth	☐	☐	Dry Mouth	☐	☐	

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or medication, I will inform the dentist at the next appointment.

Patient (or Responsible Party's)Signature:_____ **Date:**_____