WHITEHALL [redacted] DENTAL ASSOC
450 PERSHING BLVD
WHITEHALL, PA 18052

(610)434-6796

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Sex ☐M ☐F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Home Phone # ( ) _____ Cell Phone #1 ( ) _____ Email _____

Employer _____ Employer Phone ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone ( ) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone ( ) _____

RESPONSIBLE PARTY

Name of Person
Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone ( ) _____

Birthdate _____ Currently a patient in our office? ☐Yes ☐No

Employer _____ Work Phone ( ) _____

E-Mail _____ Cell Phone ( ) _____

DENTAL INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL DENTAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

MEDICAL HISTORY CONTINUED

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

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

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

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

Please list each one: _____

_____

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) ☐ Yes ☐ No
If so, when? _____

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 diseases or medical problems

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

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 Erythromycin	Y N Tetracycline
Y N Codeine	Y N Latex	Y N Other
Y N Dental Anesthetics	Y N Penicillin	

Please list any other drugs/materials that you are allergic to: _____

_____

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

Have you ever had gum treatment? ☐ Yes ☐ No

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

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Y ☐ N Do your gums ever bleed? ☐ Y ☐ N

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

How long do you use a toothbrush before replacing it? _____

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

Have you lost any teeth? ☐ Yes ☐ No If yes, why? _____

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.

_____
Signature Date

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

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

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: _____

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions.
_____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions.
_____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions.
_____
Signature Date

Do you have or have you had any disease, or condition not listed? ☐ Yes ☐ No

If yes, please list: _____

Indicate which of the following your have had, or have at present. Circle "Yes" or "No" for each item.

Heart Disease or Attack	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Hepatitis C	☐ Yes	☐ No
Heart Failure	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No	Arteriosclerosis (hardening of arteries)	☐ Yes	☐ No
Angina Pectoris	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No	AIDS	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
HIV Positive	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Cold sores/Fever blisters/ Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Cortisone Medication	☐ Yes	☐ No	Artificial Heart Valve	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Cosmetic Surgery	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No	Heart Surgery	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Bruise Easily	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Allergies or Hives	☐ Yes	☐ No	Nervousness	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No
Pain in Jaw Joints	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No	Psychiatric Treatment	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Hepatitis A (infectious)	☐ Yes	☐ No			
Artificial Joints (Hip, Knee, etc.)	☐ Yes	☐ No	Hepatitis B (serum)	☐ Yes	☐ No			

For Women Only:

Are you pregnant? ☐ Yes ☐ No

If yes, what month? _____

Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.

Patient Signature: _____ Date: _____

Dentist's Signature: _____ Date: _____

Review Date	Changes in Health Status	Patient's signature	Dentist's signature