PENNSYLVANIA CENTER FOR DENTAL IMPLANTS AND PERIODONTICS

Phone: (215) 643-4393
Fax: (215) 643-6413
140 East Butler Ave
Ambler, PA 19002

Patient Information

Title First Name M.I. Last Name Suffix Date:

I prefer to be called Email:

Address City State Zip

Home Phone Cell Phone Business Phone Ext.

Preferred Contact # Occupation: **Gender** ☐ Male ☐ Female

Date of Birth / / **Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Referred By:

Other family members seen by us:

Emergency Contact

Title First Name M.I. Last Name Suffix

Relationship to Patient

Home Phone Cell Phone Business Phone Ext.

Responsible Party

Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other:

Title First Name M.I. Last Name Suffix

Address City State Zip

Home Phone Business Phone Ext.

Date of Birth / / Occupation:

Employer

Dental Insurance

Insurance Company Name

Company Address City State Zip

Company Phone # **Group #** (Plan, Local or Policy #) **Insured ID# or SSN**

Insured's Name **Relationship to Patient**

Insured's Date of Birth / / **Insured's Employer**

Insured's Employer Address

Secondary Insurance

Insurance Company Name:

Company Address City State Zip

Company Phone # **Group #** (Plan, Local or Policy #) **Insured ID# or SSN**

Insured's Name **Relationship to Patient**

Insured's Date of Birth / / **Insured's Employer**

Insured's Employer Address

Dental Information

When was your last dental visit? What was done?
When were x-rays taken last? When was your last dental cleaning?
Reason for today's visit: Are you in pain? ☐ Yes ☐ No For how long?
Please rate your current dental health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
How do you feel about your smile?
Are you fearful of dental treatment? ☐ Yes ☐ No Please explain:

Have you ever had trouble getting numb or had reactions to local anesthetic?	☐ Yes	☐ No
Please describe:		
Do your gums bleed?	☐ Yes	☐ No
Is your mouth dry?	☐ Yes	☐ No
Teeth sensitive to heat, cold, sweets, brushing, or flossing?	☐ Yes	☐ No
Have you noticed any bad tastes or bad breath?	☐ Yes	☐ No
Have you ever had periodontal (gum) treatments?	☐ Yes	☐ No
Have you had orthodontic (braces) treatment?	☐ Yes	☐ No
Have you had any problems associated with previous dental treatment?	☐ Yes	☐ No
Do you have earaches or neck pains?	☐ Yes	☐ No
Do you have any clicking, popping or discomfort in the jaw?	☐ Yes	☐ No
Have you noticed any loose or shifting teeth?	☐ Yes	☐ No
Do you clench or grind your teeth?	☐ Yes	☐ No
Have you had headaches on a regular basis in the morning, evening, or after eating?	☐ Yes	☐ No
Have you had your bite adjusted?	☐ Yes	☐ No
Do you have sores or ulcers in your mouth?	☐ Yes	☐ No
Do you wear dentures or partials?	☐ Yes	☐ No
Have you ever had a serious injury to your head or mouth?	☐ Yes	☐ No

Health History

Please rate your current physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Height: Weight:
Date of last physical exam Are you now under the care of a physician? ☐ Yes ☐ No

Current Physician

What condition is being treated?
Physician Name Phone Number
Address City State Zip

For Women

Are you pregnant? ☐ Yes ☐ No How many weeks?
Taking birth control pills or hormonal replacement? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ Yes ☐ No
What was the illness or problem?
Are you taking or have you recently taken any prescription or over the counter medicine(s)? ☐ Yes ☐ No
Please list any medications (prescription or over the counter) you are taking:

Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
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Name		For what condition?		Dosage	
Name		For what condition?		Dosage	

Has anyone suggested you need antibiotics prior to receiving dental care? ☐ Yes ☐ No
Reason:

Have you had an orthopedic total joint (hip, knee, elbow, shoulder, finger) replacement? ☐ Yes ☐ No

Date: Have you had any complications?

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ Yes ☐ No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ Yes ☐ No Date treatment began:

Do you use controlled substances (drugs)? ☐ Yes ☐ No

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ Yes ☐ No Are you interested in quitting? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No How much do you typically drink in a week?

Allergies

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

Local anesthetics	☐ Yes	☐ No	Details:
Aspirin	☐ Yes	☐ No	Details:
Penicillin or other antibiotics	☐ Yes	☐ No	Details:
Barbiturates, sedatives, or sleeping pills	☐ Yes	☐ No	Details:
Sulfa drugs	☐ Yes	☐ No	Details:
Codeine or other narcotics	☐ Yes	☐ No	Details:
Metals	☐ Yes	☐ No	Details:
Latex (rubber)	☐ Yes	☐ No	Details:
Iodine	☐ Yes	☐ No	Details:
Hay fever/seasonal	☐ Yes	☐ No	Details:
Food	☐ Yes	☐ No	Details:
Other			

Medical Conditions

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

AIDS / HIV Positive	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Anaphylaxia	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Excessive Thirst	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Fainting Spells/Dizziness	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Heart Attack/Failure	☐ Yes	☐ No	Radiation treatment	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Pace Maker	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Heart Trouble/Disease	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hepatitis A, B or C	☐ Yes	☐ No	Stomach/Intestinal Disease	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Tumors/Growths	☐ Yes	☐ No

Do you have any disease, condition, or problem not listed above that you think we should know about? ☐ Yes ☐ No

Please explain:

Confirmation

I certify that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient Signature _____