PERSONAL CARE DENTISTRY
7046 Torresdale Avenue, Philadelphia, PA 19135
Phone: 215-335-4955

CONFIDENTIAL MEDICAL HISTORY

1. Name_____Date of Birth_____ Age_____ TODAY'S DATE:_____

HEALTH HISTORY

TO OUR PATIENTS: Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

2. Height_____Weight_____
3. Has there been a change in your medical history in the past year? Yes_____ No_____
4. Do you have a prosthetic joint? If Yes, The year placed?_____The Location of Prosthetic?_____ Yes_____ No_____
5. Have you had a heart valve replacement or vascular graft? Yes_____ No_____
6. Have you had a serious illness, operation or hospitalization in the past 5 years? Yes_____ No_____

   If Yes, please explain_____

7. Are you under the care of a physician? Provide Name, Phone Number, and Include Any Specialist Doctors you see regularly:

   _____

MEDICAL HISTORY: CIRCLE ALL THAT APPLY

Damaged Heart Valves?	**Bruise easily?**	**Problems with immune system?**
Mitral Valve Prolapse?	**Bleeding Tendency/Abnormal Bleed?**	**Delay in healing?**
Heart Murmur?	**Hepatitis, Jaundice, Liver Disease?**	**A Tumor or Growth?**
High Blood Pressure?	**Infectious Mononucleosis?**	**Cancer/Radiation Therapy/Chemotherapy?**
Low Blood Pressure?	**Gallbladder Trouble?**	**Chronic Fatigue/Night Sweats?**
Chest Pain, Angina?	**Fainting Spells?**	**Are you on a diet?**
Heart Attack(s)?	**Convulsions/Epilepsy?**	**A history of alcohol abuse?**
Irregular Heart Beat?	**Stroke?**	**A history of drug abuse?**
Pacemaker?	**Thyroid Trouble?**	**Contact lenses?**
Cardiac Pacemaker?	**Diabetes?**	**Eye Disease/Glaucoma?**
Heart Surgery?	**Low Blood Sugar?**	**Mental Health Problems/Anxiety/Depression?**
Pneumonia, Bronchitis, Chronic Cough?	**Kidney Trouble?**	**Pain or clicking of jaws when eating?**

MEDICATIONS

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8. Are you currently taking Blood Thinners(Coumadin, Plavix, Aspirin, Vitamin E, Ginkgo Biloba, Aggrenox, Pradaxa, Fish Oil)? **Yes____No____**
9. Are you currently taking, or have you ever taken, bone density medications, or bisphosphonates such as Fosamax, Boniva, Actonel, IV-Zometa, or Aredia in the past 12 years? **Yes____No____**
10. Are you currently taking Tranquilizers, Sleeping Pills, Antidepressants, and/or Narcotics on a regular basis? **Yes____No____**

11. Please list any medications you are taking at this time(INCLUDE DOSAGE AND FREQUENCY)

_____

_____

12. Please list any known allergies_____
    a. Are you allergic to
        i. Local anesthetic(numbing medications)? Yes____No____
        ii. Penicillin? Yes____No____
        iii. Other Antibiotics? Yes____No____
        iv. Sulfa drugs? Yes____No____
        v. Aspirin? Yes____No____
        vi. Amoxicillin? Yes____No____
        vii. Codeine or other narcotics? Yes____No____
        viii. Latex? Yes____No____
        ix. Soy? Yes____No____
        x. Eggs/Yolk? Yes____No____
        xi. Sulfites? Yes____No____
        xii.
13. Do you have any other medical conditions we should be aware of, if so, please explain:_____
14. Are you a smoker? How much/day and for how many years?_____
15. Do you consume alcoholic beverages? Amount?_____
16. WOMEN:
    a. Are you pregnant?_____ How many months?_____ Are you nursing?_____
    b. Are you taking birth control pills? Yes_____ No_____
    c. Is there any possibility of pregnancy? Yes_____ No_____

DENTAL HISTORY

17. Last Dental Visit?_____
18. Reason for visit today:_____

19. Have you ever had any problems associated with previous dental treatment, if so, please explain:_____

_____

CERTIFY

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form?

X_____ **X**_____ **X**_____

Signature of Patient(Parent or Guardian if Minor) **Reviewed By** **Date**

FEES AND PAYMENTS

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We make every effort to bring down the cost of your care. You can help by paying upon completion of each visit. Please remember that insurance is considered a method for reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X_____ **X**_____

Signature of Patient(Parent or Guardian if Minor) **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X_____ **X**_____

Signature of Patient(Parent or Guardian if Minor) **Date**

AUTHORIZATION

I authorize my dentist and his/her designated staff, to perform an intra and extraoral examination, for the purpose of diagnosing and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to other doctors and/or insurance carriers. I permit messages to be left on my phone concerning my appointment.

X_____ **X**_____ **X**_____ **X**_____

Signature of Patient(Parent or Guardian if Minor) **Witness** **Doctor** **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I have regarding this Notice.

X_____ **X**_____

Signature of Patient(Parent or Guardian if Minor) **Date**