Chalet Dental Care, PA

OFFICE ACQUAINTANCE & MEDICAL HISTORY

Name ______________________________ Birthdate ______________
last first middle intial

Marital Status ______________ Soc. Sec. No. ______________ Phone Number ______________

Email Address ______________________________ Cell Number ______________

Residence Address ______________ City ______________ State ________ Zip ________

Employed By ______________________________ Present Position ______________

Business Address ______________________________ Phone Number ______________

Spouse Employed By ______________________________ Present Position ______________

Business Address ______________________________ Phone Number ______________

Person Responsible for Account ______________________________

When was the last time you visited a dentist and what was done? ______________________________

____

Were X-Rays taken? ______________________________

Are your teeth sensitive? ______________ Sweets? ________ Hot? ________ Cold? ________

Are you pleased with the appearance of your teeth? ______________________________

Reason for appointment ______________________________

May we call you at work? Yes No

Whom may we thank for referring you? ______________________________

If you have insurance - either your own, your parent's or spouse's - which may assist you with a portion of your account, please complete the following:

Employee Name ______________________________

Employer ______________________________

Patient's Relationship to Employee ______________________________

Name of Insurance Company ______________________________

Is This Insurance: Medical Dental (circle) Group/File Number ______________

Employee Soc. Sec. No. ______________ Birthdate of Employee ______________

Additional Coverage

Employee Name ______________________________

Employer ______________________________

Patient's Relationship to Employee ______________________________

Name of Insurance Company ______________________________

Is This Insurance: Medical Dental (circle) Group/File Number ______________

Employee Soc. Sec. No. ______________ Birthdate of Employee ______________

over...

Chalet Dental Care, PA

OFFICE ACQUAINTANCE & MEDICAL HISTORY

Patient Name: ____________________

Medical Doctor: ____________________ Phone Number: ____________________

Clinic or Location: ____________________

Notify Emergency: ____________________ Relationship to You: ____________________ Phone Number: ____________________

Circle a definitive answer for each question:

Yes No Are you currently under the care of a physician? Describe treatment ____________________

Yes No Have you had any change in your health, any medical treatment or any physician visits this year? ____________________

Yes No Have you ever had any surgical operation of any kind? ____________________

Yes No Are you required to take a premedication prior to dental treatment? ____________________

Do you have, have you ever or have you been treated for any of the following?

Yes No Heart Murmur
Yes No Rheumatic Fever
Yes No Do you have mitral valve prolapse?
Yes No Cardiovascular disease (heart trouble, heart attack, stroke)
Yes No High Cholesterol?
Yes No Pacemaker (type) ____________
Yes No High Blood Pressure
Yes No Low Blood Pressure
Yes No Anemia, Blood Disorders
Yes No Hemophilia, bleeding or blood disorders
Yes No Do you bruise easily?
Yes No Epilepsy, Seizures
Yes No Fainting Spells
Yes No Diabetes or Hypoglycemia
Yes No Asthma or Lung Problems
Yes No Tuberculosis
Yes No Hepatitis, Jaundice or Liver Disease
Yes No Kidney Disorder
Yes No Thyroid Condition
Yes No Ulcers
Yes No Arthritis

Yes No Osteoporosis
Yes No Are you or have you ever taken Bisphosphonates?
Yes No Chronic Sinus Problem
Yes No Oral Herpes, Cold Sores
Yes No Radiation/Chemotherapy When ____________
Yes No AIDS or AIDS Related Complex (HIV)
Yes No Eating Disorder ____________ specify
Yes No Chemical Dependency
Yes No Have you ever had an allergic reaction or been told not to take certain medication? ____________
Yes No Allergies to anesthetics
Yes No Allergies to Latex rubber
Yes No Implants of any type or Joint replacement implant (type & year) ____________
Yes No Are you pregnant? ______ Due Date: ____________
Yes No Do you use any tobacco product? ____________ Daily Use ____________
Yes No Do you have any disease, condition or problem not listed? ____________

Patient's Signature ____________________ Date ____________
(or Parent's signature if patient is a minor)

Are you taking any over-the-counter or prescription medications? Yes No

Patient Initials	Update Initials	Date	Medication	Dosage