Pennridge Dental

Patient Information

Date: ____/____/_______ Social Security: ______________________ Birth date: _____/_____/______

Name: ____ Cell Phone: _______________________

Address: ____ Home Phone: ______________________

City: ____ State: ______ Zip: ________________

Sex: ☐ M ☐ F Status: ☐ Married ☐ Child ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Employer: ____ E-mail: ____________________________

Business Address: ____________________________________ Business Phone: _____________________

____ Occupation: _______________________

Whom may we thank for referring you? ____

In case of emergency, who should we contact? ___________________________ Phone: ________________

Dental Insurance-1st coverage

Name of Dental Insurance Company: ____

Dental Insurance-2nd coverage

Name of Dental Insurance Company: ____

Assignment and Release

I hereby authorize payment directly to Pennridge Dental Associates, LLC all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependants. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: ____________________________________ Date: ________________

Medications

Pharmacy: ____________________________________ Pharmacy Phone # __________________________

Medications	Dosage	Reason
1.		
2.		
3.		
4.		
5.		

Dental History

Former Dentist ______________________________ Date of last X-Rays __________________________

City, State _________________________________ How often do you floss? ______________________

Date of last Dental visit _____________________ How often do you Brush? _____________________

Patient Information

Medical History

Physicians Name: ___________________________ Phone# _________________ Date of last visit:___________

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Do you pre-medicate with antibiotics prior to dental procedures?	☐	☐
4. Do you Smoke?	☐	☐
5. Do you use alcohol or other recreational drugs?	☐	☐
6. Have you ever had a Substance Addiction?	☐	☐

7. Have you had any allergic reactions to the: Following	Yes	No
Local anesthetics (e.g. Novocain)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates (Sleeping Pills)	☐	☐
Sedatives	☐	☐
Aspirin	☐	☐
Other	☐	☐
8. (Women Only) Are you:		
Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

☐	Aids	☐	Epilepsy	☐	Pacemaker
☐	Anemia	☐	Fainting or Dizziness	☐	Psychiatric Care
☐	Arthritis, Rheumatism	☐	Glaucoma	☐	Radiation Treatment
☐	Artificial Heart Valves	☐	Headaches	☐	Respiratory Disease
☐	Artificial Joints	☐	Heart Murmur	☐	Rheumatic Fever
☐	Asthma	☐	Heart Problems	☐	Scarlet Fever
☐	Back Problems	☐	Hepatitis-Type	☐	Shortness of Breath
☐	Bleeding Problems	☐	Herpes	☐	Seizures
☐	Blood Disease	☐	High Blood Pressure	☐	Sinus Trouble
☐	Cancer	☐	HIV Positive/Aids	☐	Stroke
☐	Chemotherapy	☐	Jaundice	☐	Swelling of Feet/Ankles
☐	Circulatory Problems	☐	Jaw Pain	☐	Swollen Neck Gland
☐	Condenital Heart Disease	☐	Kidney Disease	☐	Thyroid Problems
☐	Cortisone Treatments	☐	Liver Disease	☐	Tonsillitis
☐	Cough – Persistent or bloody	☐	Low Blood Pressure	☐	Tuberculosis
☐	Diabetes	☐	Leukemia	☐	Tumor or growth on head/neck
☐	Emphysema	☐	Mitral Valve Prolapse	☐	Ulcer
				☐	Venereal Disease

I understand a broken appointment charge may be applied to my account for missed appointments or appointments canceled without 24 hours notice.
I certify that I have read and understand the above statement. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction and I will not hold Pennridge Dental Associates, LLC. or any of their staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient's Name: ____

Signature of Patient/Guardian ______________________________ Date _______________

Dr. ____ Date _______________