30 State Ave. Carlisle, PA 17013
Ph. 717-249-7777 | Fax. 717-249-3614

Patient Information

Name _____Soc. Sec. #_____
Last First MI
Address _____
City_____State_____Zip_____Home Phone _____
Cell Phone _____ Email_____
Sex ☐M☐F Age_____ Birthdate_____
Marital Status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced
Patient Employed By _____Occupation _____
Business Address_____ Business Phone_____
Business Email_____
Whom may we thank for referring you?_____
Notify in case of Emergency_____Phone Number_____
Cell Phone_____Work Phone _____
Email_____

Responsible Party Information

Last_____First_____Middle Initial _____
Relationship to Patient_____Soc. Sec. #_____
Sex ☐M☐F Marital Status_____Birthdate_____
Address_____Apt #_____
City_____State_____ Zip_____ Email _____
Cell Phone _____Home Phone_____Work Phone _____

Dental Insurance Information

Primary Insurance
Ins Co. Name_____
Ins. Address_____
Ins. Phone #_____
Group Plan # _____
Insured Name _____
Date of Birth _____
Policy ID # _____
Employer_____

Secondary Insurance
Ins Co. Name_____
Ins. Address_____
Ins. Phone #_____
Group Plan # _____
Insured Name _____
Date of Birth _____
Policy ID # _____
Employer_____

Dental History

What would you like us to do today? _____
Former Dentist _____ Address _____ Phone_____
Dentist's Email _____
Date of last dental care _____Date of last xrays _____
Check yes or no if you have had problems with any of the following:

☐Y ☐N Bad Breath
☐ Y☐N Bleeding Gums
☐Y☐N Clicking or popping jaw
☐Y☐N Sensitivity to Sweets
☐Y☐N Food Collection between teeth
☐Y☐N Grinding or clenching teeth
☐Y☐N Loose teeth or broken fillings
☐Y☐N Sensitivity when biting
☐Y☐N Periodontal Treatment
☐Y☐N Sensitivity to cold
☐Y☐N Sensitivity to hot
☐Y☐N Sores or growths in mouth

How often do you brush your teeth?_____Floss?_____
How do you feel about the appearance of your teeth?_____
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐Y ☐N
Other information about your dental health or previous treatment_____

Medical History

Physician's name_____Phone_____
Date of last visit_____Have you had any serious illness or operations? ☐Y ☐N
If yes, describe_____
Are you currently under physician care? ☐Y☐N If yes, describe_____
Have you ever had a blood transfusion? ☐Y☐N If yes, describe_____
Have you ever taken Fen-Phen/Redux? ☐Y☐N
Are you taking or have taken bisphosphonate drugs? Circle below if yes.
Fosamax Boniva Actonel Skelid Didronel IVAredia IV Zometa Any others:_____
Women: Are you pregnant? ☐Y☐N Nursing? ☐Y☐N Taking Birth Control Pills? ☐Y☐N

Check yes or no whether you have had any of the following:

☐Y☐N AIDS/HIV Positive
☐Y☐N Anaphylaxis
☐Y☐N Anemia
☐Y☐N Arthritis,Rheumatism
☐Y☐N Artificial Heart Valves
☐Y☐N Artificial Joints
☐Y☐N Asthma
☐Y☐N Atopic (Allergy Prone)
☐Y☐N Back Problems
☐Y☐N Blood Disease
☐Y☐N Cancer
☐Y☐N Chemical Dependency
☐Y☐N Chemotherapy
☐Y☐N Circulatory Problems
☐Y☐N Cortisone Treatments
☐Y☐N Cough, Persistent
☐Y☐N Cough up blood
☐Y☐N Diabetes
☐Y☐N Epilepsy
☐Y☐N Fainting
☐Y☐N Food Allergies
☐Y☐N Glaucoma
☐Y☐N Headaches
☐Y☐N Heart Murmur
☐Y☐N Heart Problems
Describe_____
☐Y☐N Hemophilia/ Abnormal Bleeding
☐Y☐N Herpes
☐Y☐N Hepatitis
☐Y☐N High Blood Pressure
☐Y☐N Jaw Pain
☐Y☐N Kidney Disease or malfunction
☐Y☐N Liver Disease
☐Y☐N Material Allergies (latex, wool, metal, chemicals)
☐Y☐N Mitral Valve Prolapse
☐Y☐N MRSA
☐Y☐N Nervous Problems
☐Y☐N Psychiatric Care
☐Y☐N Pacemaker/Heart Surgery
☐Y☐N Rapid weight gain/loss
☐Y☐N Radiation Treatment
☐Y☐N Respiratory Disease
☐Y☐N Rheumatic/Scarlet Fever
☐Y☐N Shingles
☐Y☐N Shortness of Breath
☐Y☐N Skin Rash
☐Y☐N Spina Bifida
☐Y☐N Stroke
☐Y☐N Surgical Implant
☐Y☐N Swelling of feet or ankles
☐Y☐N Thyroid Disease or Malfunction
☐Y☐N Tobacco Habit
☐Y☐N Tonsilitis
☐Y☐N Tuberculosis
☐Y☐N Ulcer/Colitis
☐Y☐N Venereal Disease

Signature_____Date_____

Does Patient have any Drug Allergies? ☐Y ☐N If yes, list all below:

_____

_____

Is patient currently taking any medications? ☐Y ☐N If yes, list all below:

Medication Name	Dosage/Frequency	Reason

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for servies rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____Date_____

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