WYOMISSING DENTISTRY

DR. SKAF & DR. BLACKBURN

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining our dental health.

Patient Information

Legal Name: _____
First Name *Middle Initial* *Last Name* *(Preferred Name)*

Address:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____Ext:___

Email: _____

Birth Date: _____ Soc. Sec: _____ Occupation:_____

Gender as recorded with Insurance company: ◯Male ◯Female ◯Other: _____

Age: _____ ◯Single ◯Married ◯Widowed ◯Separated ◯Divorced

Notify in case of emergency: _____ Contact# _____

Email: _____

Primary Insurance Information

Name of Insured: _____

Relationship to the Insured ◯Self ◯Spouse ◯Child ◯Other

Insured Soc. Sec: _____ Insured Date of Birth: _____

Employer: _____

Insurance Company_____ Insurance Phone#: _____

Member ID: _____ Group # _____

Secondary Insurance Information

Name of Insured: _____

Relationship to the Insured ◯Self ◯Spouse ◯Child ◯Other

Insured Soc. Sec: _____ Insured Date of Birth: _____

Employer: _____

Insurance Company_____ Insurance Phone#: _____

Member ID: _____ Group # _____

MEDICAL HISTORY

WYOMISSING DENTISTRY
DR. SKAF & DR. BLACKBURN

Patient Name: _____ **Birth Date:** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your body. Health problems that you may have, or medication that you may be taking could have an important relationship with the dentistry you will receive. Thank you for answering the following questions.

Former Dentist _____ Date of last dental care: _____
How often do you brush? _____ Floss? _____ Dental Implants? _____ Pain?____
How do you feel about the appearance of your teeth? _____
Have you ever experienced an adverse reaction in conjunction with a medical or dental procedure? _____
Other information about your dental health or previous treatment _____
Are you under a physician's care now? ◯Yes ◯No If yes, please explain:_____
_____
Have you ever had a serious head or neck injury? ◯Yes ◯No If yes, please explain:_____
Do you take or have taken, Phen-Fen or Redux? ◯Yes ◯No If yes, please explain:_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
◯Yes ◯No If yes, please explain:_____

Check (✔) yes or no if you have had problems with any of the following:

__ Bad breath __ Food collection between teeth __ Periodontal treatment __ Sensitivity to sweets
__ Bleeding Gums __ Grinding or clenching teeth __ Sensitivity to cold __ Sensitivity with biting
__ Clicking or popping Jaw __ Loose teeth or broken fillings __ Sensitivity to hot __ Sores

WOMEN: Are you pregnant? __Yes __No **Nursing**? __Yes __No **Taking Birth Control pills**? __Yes __No

Are you allergic to any of the following?
☐Aspirin ☐Penicillin ☐ Codeine ☐ Local Anesthetics ☐acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ Other - please specify _____ Is the patient currently taking any medications? If yes, list all
_____

Check (✔) if you have or had any of the following:

__ AID?HIV positive
__ Anaphylaxis
__ Anemia
__ Arthritis, Rheumatism
__ Artificial heart valve
__ Artificial Joints
Date:_____
__ Asthma
__ Atopic(allergy prone)
__ Back Problems
__ Blood Disease
__ Cancer
__ Chemical Dependency
__ Tonsillitis
__ Chemotherapy
__ Circulatory Problems
__ Cough,persistent
__ Cough up blood
__ Diabetes
__ Epilepsy
__ Fainting
__ Food allergies
__ Glaucoma
__ Migraine
__ Heart Problems
describe: _____
__ Hemophilia/Abnormal Bleeding
__ Herpes
__ Hepatitis
__ High Blood Pressure
__ Cortisone Treatments
__ Jaw pain
__ Kidney disease/ malfunction
__ Liver disease
__ Mitral valve prolapse
__ Pacemaker
__ Psychiatric Care
__ Weight gain/loss(excessive)
__ Radiation Treatment
__ Respiratory Disease
__ Rheumatic/scarlet fever
__ Shingles
__ Shortness of Breath
__ Skin Rash
__ Spina Bifida
__ Material Allergies:_____ (latex,wool,metal,chemicals)
__ Stroke
__ Surgical Implant
__ Swelling of feet/Ankle
__ Thyroid Disease
__ Tobacco Habit
__ Tonsillitis
__ Tuberculosis
__ Ulcer/Colitis
__ Venereal Disease
__ Open Heart Surgery date:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's health). It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN:_____ **DATE:** _____