Exton & Malvern
DENTAL
Medicine Associates

PATIENT REGISTRATION

Patient: (Mr., Mrs., Ms., Miss., Master, Dr.)

First Name _____ M.I ____ Last Name _____

Sex: ❑ Male ❑ Female Date of Birth _____ Age ____ Social Security # _____

Street _____

City _____ State ____ Zip _____

Home Tel.# (____) _____ Business Tel.# (____) _____ Ext. _____

Cell Phone _____ Email _____

What is your chief complaint for seeking dental treatment? _____

How long has it been since your last dental appointment? _____

Have you ever responded adversely to Dental Treatment or dental anesthetic? ❑ Yes ❑ No

Is there anything else we should know about your dental history? _____

In case of emergency, who should be notified? _____ Phone _____

Whom may we thank for referring you? _____

PATIENT ACCOUNT INFORMATION

Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single ❑

Employed: Full Time ❑ Part Time ❑ Retired ❑ Not ❑

Student: Full Time ❑ Part Time ❑ School Name/Address _____

_____

Who will be responsible for your account? ❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other

Name _____ Soc. Sec. #: _____ Home Tel.: (____) _____

Street _____ City _____ State ____ Zip _____

Employer _____ Tel.: (____) _____

PRIMARY DENTAL INSURANCE:

Insurance Co. _____

Address _____

_____

Tel.# (____) _____

Group # _____ Group Name _____

I.D. # _____

DENTAL SUBSCRIBER'S INFORMATION:

Name _____

Relation to patient: ❑ Self ❑ Spouse ❑ Child ❑ Parent ❑ Other

Sex: ❑ Male ❑ Female Date of Birth _____

Employer Name _____

Address: Street _____

City _____ State ____ Zip _____

Tel. # (____) _____

SECONDARY DENTAL INSURANCE:

Insurance Co. _____

Address _____

_____

Tel.# (____) _____

Group # _____ Group Name _____

I.D. # _____

DENTAL SUBSCRIBER'S INFORMATION:

Name _____

Relation to patient: ❑ Self ❑ Spouse ❑ Child ❑ Parent ❑ Other

Sex: ❑ Male ❑ Female Date of Birth _____

Employer Name _____

Address: Street _____

City _____ State ____ Zip _____

Tel. # (____) _____

HEALTH HISTORY

To our patients: The scope of dental medicine includes the diagnosis and adjunctive treatment of diseases, injuries and defects involving both the functional and aesthetic aspects of the hard and soft tissues of the oral and maxillofacial regions. Health problems may effect the outcome of treatment. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

		Yes	No
100.	Are you in good health? Height _____ Weight _____	❑	❑
101.	Have there been any changes in your general health in the past year?	❑	❑
102.	Are you under the care of a physician? Date of last visit: _____	❑	❑
	Physician Name _____ Phone No. _____		
103.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
	_____		
104.	Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If so describe where _____	❑	❑
105.	Do you have a prosthetic joint? If so, describe where _____	❑	❑

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE ...	Yes	No	NOTES		HAVE YOU HAD OR DO YOU CURRENTLY HAVE ...	Yes	No	NOTES
106	Rheumatic fever?				132	Stroke?			
107	Damaged heart valves/ mitral valve prolapse?				133	Thyroid trouble?			
					134	Diabetes?			
108	Heart murmur? NOT INNOCENT w/regirt.				135	Low blood sugar?			
109	High blood pressure?				136	Kidney trouble?			
110	Low blood pressure?				137	Are you on dialysis?			
111	Chest pain, angina?				138	Swollen Ankles, arthritis or joint disease?			
112	Heart attack(s)?								
113	Irregular heart beat?				139	Stomach ulcers?			
114	Cardiac pacemaker?				140	Sexually transmitted diseases?			
115	Heart surgery?				141	HIV and/or related complications?			
116	Bronchitis, chronic cough?				142	Do you have any reason to be immunosuppressed?			
117	Asthma?								
118	Hayfever / Sinus problems?				143	Delay in healing?			
119	Tuberculosis?				144	Cancer?			
120	Emphysema?				145	A tumor or growth?			
121	Difficult breathing/other lung trouble?				145	X-Ray treatment/chemotherapy?			
122	Do you smoke?				146	Chronic Fatigue/night sweats?			
123	Blood transfusion?				147	Malignant Hyperthermia?			
124	Blood disorder such as anemia?				148	Are you on a diet?			
125	Bruise easily?				149	A history of drug abuse?			
126	Bleeding tendency (abnormal bleed)?				150	A history of alcohol abuse?			
127	Jaundice, hepatitis or liver disease?				151	Eye disease/glaucoma?			
128	Infectious mononucleosis?				152	Mental health problems?			
129	Gallbladder trouble?				153	Psychiatric care?			
130	Fainting spells?				154	Pain & Clicking of jaws when eating?			
131	Convulsions, epilepsy?				155	Sleep Apnea/Fatigue/snoring?			

MEDICATION

PLEASE LIST CURRENT MEDICATIONS (additional space on back, if needed)

ALLERGIES

	ARE YOU ALLERGIC TO OR HAD A REACTION TO...	Yes	No	NOTES		ARE YOU ALLERGIC TO OR HAD A REACTION TO...	Yes	No	NOTES
206	Local Anesthetics?				210	Aspirin?			
207	Penicillin?				211	Codeine or other narcotics?			
208	Other antibiotics?				212	Other medications?			
209	Sodium Penthothal, valium, or other tranquilizers?				213	Allergies other than drug allergies (Please list)			

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD?
Yes ☐ **No** ☐ _____

Is there a family history of:
Cancer Yes ☐ No ☐ **Diabetes** Yes ☐ No ☐ **Heart Disease** Yes ☐ No ☐ **Anesthetic Problems** Yes ☐ No ☐

WOMEN

		Yes	No	NOTES			Yes	No	NOTES
214	Is there a possibility of pregnancy?				216	Are you nursing?			
215	Estimated delivery date? / /				217	Are you taking birth control pills?			

WOMEN NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and 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 dentist, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: _____ Date: _____
(Parent or Guardian if minor)

FEES & PAYMENTS

We make every effort to keep down the cost of your dental health care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of 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.**

I hereby acknowledge that I am responsible for payment of services rendered by Exton Dental Medicine Associates, P.C. and I agree to pay for such services and if full payment is not made within (90) ninety days, I agree to pay any other amounts incidental to payment for services (which included monthly interest which corresponds to 18% annual interest, including the collection fee if my account goes to a collection agency and court costs if my account goes to court.)

I hereby authorize payment directly to Exton Dental Medicine Associates of the dental benefits for services rendered. I authorize Exton Dental Medicine Associates to release to my insurance company any information acquired in the course of my examination or treatment.

Signature of patient: _____ _____
(Parent if minor) (Date)

A COPY OF THIS DOCUMENT MAY BE CONSIDERED AS VALID AS THE ORIGINAL