

VALLEY DENTAL CARE

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654 Red Lion Road
Huntingdon Valley, PA. 19006
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PERSONAL HISTORY

Name _____ Please circle: Miss Ms. Mrs. Mr. Dr.
What would you like us to call you? _____
Address _____
Telephone / Home # _____ Cell # _____
Work # _____ E-Mail _____
Date of Birth _____ Occupation _____
Employer _____
Social Security # _____ Marital Status _____

Spouse's Name _____
Telephone / Work # _____ Cell # _____
Date of Birth _____ Occupation _____
Employer _____
Social Security # _____

Whom may we thank for referring you to our office? _____

Who is financially responsible for this account? _____
Address (if different from above) _____
Telephone (if different from above) _____

Please answer if you are covered by **your own** dental insurance:
Insurance Co Name _____ Group # _____
Mail claims to _____

Please answer if you are covered by a **spouse's or parent's** insurance:
Insurance Co Name _____ Group # _____
Agreement or Policy # _____
Mail claims to _____

MEDICAL HISTORY

Please Circle (Y = Yes N = No U = Uncertain)

Are you presently under the care of a physician for any illness or disorder?.....Y N U
If yes, please specify: _____
Are you pregnant?.....Due Date?.....Y N U
Are you currently taking any medications?.....Y N U
If yes, please specify: _____
Are you allergic to any medications?.....Y N U
If yes, please specify: _____
Have you been hospitalized in the past two years?.....Y N U
If yes, for what? _____
Have you ever had a heart attack or stroke?.....Y N U
If yes, when? _____
Do you smoke or chew tobacco?.....Y N U
Have you gained or lost much weight recently?.....Y N U

Do you have or have you ever had any of the following?

Heart disease?.....Y N U
High blood pressure?.....Y N U
Defective heart valve?.....Y N U
Heart murmur?.....Y N U
Heart valve replacement?.....Y N U
Artificial blood vessels?.....Y N U
Rheumatic fever?.....Y N U
Hepatitis?.....Y N U
Acquired Immune Deficiency Syndrome?.....Y N U
Any infectious disease?.....Y N U
Arthritis?.....Y N U
Epilepsy?.....Y N U
Respiratory disease?.....Y N U
Food or environmental allergies?.....Y N U
Sinus disorders?.....Y N U
Kidney disorders?.....Y N U
Nervous or mental problems?.....Y N U
Fainting spells?.....Y N U
Anemia?.....Y N U
Prolonged bleeding?.....Y N U
Blood disorders?.....Y N U
Healing complications?.....Y N U
Difficulty hearing?.....Y N U
Diabetes?.....Y N U
Chronic thirst or frequent urination?.....Y N U
Alcohol or drug abuse problems?.....Y N U
Convulsions?.....Y N U
Severe headaches?.....Y N U

Family Physician: _____ Address & Telephone _____

Medical Specialist: _____ Address & Telephone _____

What Specialty? _____

Date of Last Medical Exam: _____

DENTAL HISTORY

Please write your primary reason for coming to our office: _____

1. Are you having problems with your teeth?.....Y N U
2. Are your teeth sensitive to heat?.....Y N U
3. Are your teeth sensitive to cold?.....Y N U
4. Are your teeth sensitive to sweets?.....Y N U
5. Are your teeth sensitive to biting or chewing?.....Y N U
6. Do you grind or clench your teeth?.....Y N U
7. Are your teeth worn down?.....Y N U
8. Do any teeth feel loose?.....Y N U
9. Do you have swollen gums?.....Y N U
10. Do your gums bleed when brushing or flossing?.....Y N U
11. Does food trap between your teeth?.....Y N U
12. Are your teeth crowded together?.....Y N U
13. Do you dislike the appearance of your teeth?.....Y N U
14. Are your teeth discolored?.....Y N U
15. Are you dissatisfied with any existing fillings or crowns?.....Y N U
16. Does your bite seem uneven or uncomfortable?.....Y N U
17. Are you missing any teeth other than your wisdom teeth?.....Y N U
18. Have any of your teeth shifted?.....Y N U
19. Would you like any missing teeth replaced?.....Y N U
20. Do you have difficulty opening or closing your jaw?.....Y N U
21. Does your jaw click or pop when opening or closing?.....Y N U
22. Do you have pains in the side of your face or frequent headaches?.....Y N U
23. Has your bite ever been adjusted?.....Y N U
24. Have you ever worn braces?.....Y N U
25. Do you or have you ever premedicated with an oral antibiotic forY N U
dental treatment?

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM