519 Davisville Rd.
Willow Grove, PA 19090
1-800-975-2503
www.WillowGroveDentistry.com

Welcome!

The benefits of a healthy, happy smile are immeasurable! Our main goal is to help you achieve and maintain your maximum oral health and a smile you are proud to show off. **Please fill out this form as completely as possible.** We want to make sure that we are well informed about your medical history, current medications, and any other factor that might affect your dental health and treatment. The better we communicate, the better able we are to take great care of you.

ABOUT YOU

Today's Date: _____ How did you hear about us? _____

Name (First, Middle, Last): _____

I prefer to be addressed as: _____ Circle One: **Male** **Female**

Birthdate: _____ Age: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Employer: _____ Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Circle One: **Single** **Married** **Widowed** **Divorced** **Separated** **Partnered**

When and where are the best times to reach you? _____

Other Family Members Seen by Us: _____

EMERGENCY CONTACT (Please specify someone who does not live in your household)

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

DENTAL INSURANCE

Person Responsible for Account (If other than yourself): _____

Do you have dental insurance coverage? **Yes** **No**

Dental Insurance Co. Name: _____

Dental Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Dental Insurance Co. Phone: _____

Group # (Plan, Local, or Policy#): _____

Insured's Name: _____ Relationship: _____

Insured's Birthdate: _____ SS#: _____

Insured's Home Phone: _____ Alt. Phone: _____

Insured's Employer: _____ Occupation: _____

The above information is correct to the best of my knowledge, and I understand my information will be held in the strictest of confidence. I understand it is my responsibility to inform the office of any changes in my insurance status. I authorize the dentist and staff to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health/dental care for the purpose of submitting insurance claims. I authorize payment of insurance benefits directly to the office, otherwise payable to me.

Signature: _____

Date: _____

I understand that I will be required to pay my **estimated** portion of Willow Grove Dentistry's fees at the time of treatment unless prior arrangements have been made. I also understand that I am ultimately responsible for payment of any and all services rendered, regardless of insurance reimbursement. **See additional financial policies on Page 3.**

Signature: _____

Date: _____

MEDICAL HISTORY

Do you have a physician? **Yes** **No** Physician's Name: _____ Phone: _____

Date of Last Physical: _____ Current Physical Health: **Excellent** **Good** **Fair** **Poor** **Very Poor**

Are you currently under the care/supervision of a physician? **Yes** **No** Please Explain: _____

Are you currently taking any prescription medications? **Yes** **No** **Please List Medications with Correlating Diagnosis:** _____

_____

For Women: Are you currently taking any oral contraceptives (birth control pills)? **Yes** **No** Are you pregnant? **Yes** **No** Are you nursing? **Yes** **No**

Do you or have you ever used tobacco in any form? **Yes** **No** If yes, how much? _____ For how long? _____

Are you currently, or have you ever taken **Bisphosphonate*** medication? **Yes** **No** *includes but not limited to: Fosamax, Boniva, Actonel, Aredia, Zometa, Didronel, Reclast

ALLERGIES - Circle any and all of the following to which you are allergic:

Aspirin • Barbiturates/Sleeping Pills • Codeine • Dental Anesthetics • Erythromycin • Ibuprofen/Motrin • Jewelry/Metals • Latex • Penicillin • Tetracycline

Please list any other medications and/or materials to which you think you are allergic: _____

MEDICAL CONDITIONS

Have you ever had any of the following medical conditions? **Circle "Yes" or "No."**

Abnormal Bleeding	**Yes**	**No**	Frequent Headaches	**Yes**	**No**	Mitral Valve Prolapse	**Yes**	**No**
Alcohol or Drug Abuse	**Yes**	**No**	Glaucoma	**Yes**	**No**	Organ Transplant	**Yes**	**No**
Anemia	**Yes**	**No**	Hay Fever	**Yes**	**No**	Pacemaker	**Yes**	**No**
Arthritis/Gout	**Yes**	**No**	Heart Attack	**Yes**	**No**	Psychiatric Problems	**Yes**	**No**
Artificial Bones/Joints/Valves	**Yes**	**No**	Heart Murmur	**Yes**	**No**	Radiation Treatment	**Yes**	**No**
Asthma/Breathing Problems	**Yes**	**No**	Heart Surgery	**Yes**	**No**	Rheumatic/Scarlet Fever	**Yes**	**No**
Blood Transfusion	**Yes**	**No**	Hemophilia/Blood Disorders	**Yes**	**No**	Seizures	**Yes**	**No**
Bruise Easily/Excessive Bleeding	**Yes**	**No**	Hepatitis	**Yes**	**No**	Shingles	**Yes**	**No**
Cancer/Chemotherapy	**Yes**	**No**	Herpes/Fever Blisters/Cold Sores	**Yes**	**No**	Sickle Cell Disease/Traits	**Yes**	**No**
Colitis	**Yes**	**No**	High Blood Pressure	**Yes**	**No**	Sinus Problems	**Yes**	**No**
Congenital Heart Disease	**Yes**	**No**	HIV or AIDS	**Yes**	**No**	Stomach/Intestinal Disorders	**Yes**	**No**
Diabetes	**Yes**	**No**	Hospitalized for Any Reason	**Yes**	**No** (If yes, please explain below.)			
Difficulty Breathing	**Yes**	**No**	Kidney Problems/Dialysis	**Yes**	**No**	Stroke	**Yes**	**No**
Emphysema	**Yes**	**No**	Liver Disease	**Yes**	**No**	Thyroid Problems	**Yes**	**No**
Epilepsy	**Yes**	**No**	Low Blood Pressure	**Yes**	**No**	Tuberculosis/TB	**Yes**	**No**
Fainting Spells	**Yes**	**No**	Lung Disease	**Yes**	**No**	Ulcers	**Yes**	**No**
						Venereal Disease	**Yes**	**No**

Please explain any serious medical conditions you have ever had: _____

_____

DENTAL HISTORY

Why have you come to our office today? _____ Are you in pain? **Yes** **No** If yes, for how long? _____

Previous Dentist: _____ Phone: _____ Last Visit Date: _____

What was done? _____ Date of Last Cleaning: _____ Date of Last Dental X-rays: _____

Have you ever been told that you require antibiotics before dental treatment? **Yes** **No**

Do you have or have you ever had any of the following conditions, ailments, or treatments? **Circle "Yes" or "No."**

Bad Breath	**Yes**	**No**	Food Collection Between Teeth	**Yes**	**No**	Pain Around Ear	**Yes**	**No**
Bleeding Gums	**Yes**	**No**	Foreign Objects in Mouth	**Yes**	**No**	Pain When Brushing	**Yes**	**No**
Blisters on Lips or in Mouth	**Yes**	**No**	Grinding Teeth	**Yes**	**No**	Periodontal Treatment	**Yes**	**No**
Broken Fillings	**Yes**	**No**	Gums Swollen or Tender	**Yes**	**No**	Sensitivity to Cold	**Yes**	**No**
Burning Sensation on Tongue	**Yes**	**No**	Jaw Pain	**Yes**	**No**	Sensitivity to Heat	**Yes**	**No**
Chew on Only One Side	**Yes**	**No**	Jaw Fatigue	**Yes**	**No**	Sensitivity to Sweets	**Yes**	**No**
Clenching of Teeth	**Yes**	**No**	Lip or Cheek Biting	**Yes**	**No**	Sensitivity When Chewing	**Yes**	**No**
Clicking or Popping of Jaw	**Yes**	**No**	Loose Teeth	**Yes**	**No**	Sores or Growths in Mouth	**Yes**	**No**
Dry Mouth	**Yes**	**No**	Orthodontic Treatment	**Yes**	**No**	Worn Down Teeth	**Yes**	**No**

Have you ever had a serious/difficult problem associated with any previous dental work? **Yes** **No** Do you ever experience pain in your jaw joint (TMJ/TMD)? **Yes** **No**

How would you classify your current dental health? **Excellent** **Good** **Fair** **Poor** **Very Poor**

On a scale of 1-10, how would you rate your smile (10 being the best)? 1 2 3 4 5 6 7 8 9 10

Would you like whiter teeth? **Yes** **No** Would you like fresher breath? **Yes** **No** What else about your smile would you like to change? _____

Do you feel anxiety about dental treatment? **Yes** **No** On a scale of 1-10, how would you rate your anxiety (10 being the most anxious)? 1 2 3 4 5 6 7 8 9 10

On average, how many times a day do you brush? _____ How many times a week do you floss? _____ What type of bristles does your toothbrush have? **Soft** **Medium** **Hard**

To the best of my knowledge , the above listed medical information is truthful and accurate. Any changes to my health status and/or medications will be presented to the dentist and staff at the next appointment without fail.

Patient Signature: _____ Date: _____ BP _____

Reviewed by Doctor: _____ Date: _____ P _____