Gettysburg Dental Associates

353 York Street Front • Gettysburg, PA 17325-1955

Gettysburg Dental ASSOCIATES
Your Smile Center for Oral Health

Patient Information

Patient's Name _____ Birthdate _____ Sex: ☐ M ☐ F

Social Security No. _____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient's Address _____ Phone _____

Street City State Zip

E-Mail Address _____ Cell Phone _____

Patient's Employer _____ Occupation _____ No. of years employed? ____

Business Address _____ Phone _____ Can we call you at work? ☐ Yes ☐ No

Hobbies _____

Name of Spouse _____ No. of dependents _____ Spouses Soc. Sec. No. _____

Spouse's Employer _____ Whom may we thank for referring you? _____

Emergency Contact (Name & Number) _____

Who will pay this account? (Whose name will appear on billing statement) ☐ Self ☐ Spouse ☐ Parent or guardian

Person Responsible For This Account Other Than Above Named Patient

Responsible Party's Name _____ Birthdate _____ Sex: ☐ M ☐ F

Patient's Address _____ Phone _____

Street City State Zip

Responsible Party's Employer _____ No. of years employed _____ Soc. Sec. No. _____

Business Address _____ Phone _____

For Patients Covered By Insurance

Subscriber's Name _____ Birthdate _____ Soc. Sec. No. _____

Subscriber's Employer _____

Insurance Co. _____ Group No. _____

Patient's relationship to sub.? ☐ Self ☐ Spouse ☐ Dependent / Have you used your dental ins. previously? ☐ Yes ☐ No

Have you used your insurance at any other dental office this year? ☐ Yes ☐ No

Are you covered under more than one dental plan? ☐ Yes ☐ No (If Yes, please fill out Secondary Insurance)

Secondary Insurance

Subscriber's Name _____ Birthdate _____ Soc. Sec. No. _____

Insurance Co. _____ Group No. _____

Employer _____ Relationship to Patient _____

It is understood that I, or we, will be responsible for all charges incurred on this account, to include all present and future services. I do understand that regardless of the insurance coverage that I might have, I am responsible for paying all charges. In the event of nonpayment of charges for services rendered, I agree to pay all costs of collection, including a reasonable attorney's fee, and I further hereby waive all rights of exemption as to personal property under the Constitution and laws of the State of Pennsylvania. I have read this agreement and do understand its provisions.

Patient Signature _____ Date _____

- OVER -

MEDICAL / DENTAL HISTORY

General health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Date of last physical: _____

Name and address of Physician:

_____

Are you taking any prescription, over-the-counter or herbal medications? ☐ Yes (list below) ☐ No

_____

_____

Describe any current medical treatment, including drugs and impending operations:

_____

There are many medical situations which can affect or be affected by the procedures or drugs used for dentistry. Therefore, please fill out the following carefully.

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING: - INDICATE WITH (X)

☐ Heart disease	☐ Herpes Simplex I, II or HPV	☐ Osteoporosis/Osteopenia
☐ Heart valve replacement	☐ Kidney problems	☐ Stroke/CVA
☐ Abnormal blood pressure	☐ Glaucoma	☐ AIDS/HIV
☐ High cholesterol	☐ Artificial joints	☐ Autoimmune disorders
☐ Ulcers	☐ Do you take a blood thinner?	☐ COPD/Emphysema
☐ colitis	☐ Thyroid problems	☐ GERD
☐ Tuberculosis	☐ Heart murmur	☐ Arthritis
☐ Diabetes – Type 1 ☐ Type 2 ☐	☐ Asthma	☐ Serious accident
☐ Epilepsy	☐ Hepatitis Type ____	☐ Cancer
☐ Congenital heart defects	☐ Liver problems	☐ Anemia
☐ Persistent cough	☐ Eye disorders	**Blood Pressure** _____

Have you ever been treated with chemo or radiation therapy? ☐ Yes ☐ No

List allergies to latex, foods and medications:

_____

Are you subject to excessive bleeding from cuts or extractions? ☐ Yes ☐ No

Are you subject to fainting or dizzy spells? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No – If so, when are you expecting _____

Name of doctor _____ Are you taking birth control? ☐ Yes ☐ No

Date of last dental exam _____ Any previous major dental treatment? ☐ Yes ☐ No When? _____

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

☐ Pain around ear	☐ Difficulty opening widely	☐ Orthodontic treatment
☐ Unusual sounds in ear while eating	☐ Unfavorable dental experience	☐ Mouth breathing
☐ Frequent headaches	☐ Complications from extractions	☐ Gum disease/treatment
☐ Sleep apnea/CPAP	☐ Burning tongue	

Have you noticed any of the following signs of gum disease?

☐ Bleeding gums during toothbrushing	☐ Pus between the teeth and gums
☐ Red, swollen or tender gums	☐ Loose or separating teeth
☐ Gums that have pulled away from the teeth	☐ Change in the way your teeth fit together
☐ Persistent bad breath	☐ Food catching between teeth

Is it important to keep your teeth for as long as possible? ☐ Yes ☐ No

If you have missing teeth, why have you not had them replaced?

_____

Do you like the appearance of your smile? ☐ Yes ☐ No Do you brush daily? _____ Times/Day

Do you like the color of your teeth? ☐ Yes ☐ No Do you floss daily? _____Times/Day

Do your teeth keep you from eating any specific food? ☐ Yes ☐ No

I hereby verify that the above information is true and correct.

Patient/Legal Guardian Signature **Date**