MAIN LINE
DENTAL HEALTH ASSOCIATES

THE POWER OF A BEAUTIFUL SMILE.

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you

SS #_____

Today's Date_____

Email Addresss _____

Patient Information

Name_____ Nick Name _____

Birthdate _____Home Phone (_____) _____ Cell Phone (_____) _____

Address_____ City_____ State_____ Zip_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse or Parent's Name_____ Work Phone (_____)_____

If Patient is a Student, Name of School/College_____ City_____ State_____

How did You Hear about our Practice? _____

Person to Contact in Case of Emergency_____Phone (_____)_____

Responsible Party

Name of Person Responsible for this Account_____ Relation to Patient_____

Address_____ Home Phone (_____)_____

Driver's License #_____ Birthdate_____

Employer_____Work Phone (_____)_____

Employer's Address_____ City _____ State_____ Zip _____

Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information (dental only)

Name of Insured_____ Relation to Patient_____

Birthdate_____Social Security #_____Date Employed_____

Employer_____Work Phone (_____)_____

EmployerAddress_____City_____State_____Zip_____

Insurance Company_____Group #_____Union or Local #_____

Address_____City_____State_____Zip_____

Insurance Company Telephone #_____

Additional Insurance (dental only)

Name of Insured_____ Relation to Patient_____

Birthdate_____Social Security #_____Date Employed_____

Employer_____Work Phone (_____)_____

EmployerAddress_____City_____State_____Zip_____

Insurance Company_____Group #_____Union or Local #_____

Address_____City_____State_____Zip_____

Insurance Company Telephone #_____

(OVER →)

DENTAL HISTORY

Reason for today's visit_____ Date of last dental visit_____

Former Dentist_____ Date of last dental x-rays_____

Address_____ Phone # _____

(x) If you have had any of the following:

☐ Bad Breath	☐ Grinding teeth	☐ Sensitivity to heat
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growth in your mouth

How often do you floss? _____ How often do you brush?_____

If you could change anything about your smile, what would you change?_____

_____

MEDICAL HISTORY

Physician's Name _____ Phone #_____

Date of last visit_____ Is Your Current Physical Health? ☐ Good ☐ Fair ☐ Poor

Have you ever taken any of the group of drugs collectively reffered to as "fen-phen" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Do you Smoke or use Tobacco of any Form? ☐ Yes ☐ No Taking anti-arthritis medication? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check if you have had any of the following:

☐ Abnormal Bleeding	☐ Circulatory Problems	☐ Hepatitis	☐ Shortness of Breath
☐ Anemia	☐ Cortisone Treatments	☐ High Blood Pressure	☐ Sinus Trouble
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ HIV/AIDS	☐ Skin Rash
☐ Artificial Heart Valves	☐ Cough up Blood	☐ Jaw Pain	☐ Stroke
☐ Artificial Joints	☐ Diabetes	☐ Kidney Disease	☐ Swelling of Feet or Ankles
☐ Asthma	☐ Epilepsy	☐ Liver Disease	☐ Thyroid Problems
☐ Back Problems	☐ Fainting	☐ Mitral Valve Prolapse	☐ Tobacco Habit
☐ Blood Disease	☐ Glaucoma	☐ Pacemaker	☐ Tonsillitis
☐ Bruise Easily	☐ Headaches	☐ Radiation Treatment	☐ Tuberculosis
☐ Cancer	☐ Heart Murmur	☐ Respiratory Disease	☐ Ulcer
☐ Chemical Dependency	☐ Heart Problems	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Hemophilia	☐ Scarlet Fever	

List medications (including non-prescription medications)you are currently taking and the correlating diagnosis:_____

_____

Are you Allergic to:

Aspirin	☐ Yes	☐ No	Latex	☐ Yes	☐ No
Codeine	☐ Yes	☐ No	Other Antibiotics	☐ Yes	☐ No _____
Dental Anesthetics	☐ Yes	☐ No	Penicillin	☐ Yes	☐ No

Please List Other Drugs or Materials You are Allergic to:

_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowlege. I understand that I am financially responsible for all charges whether or not paid by insurance to me directly. After 45 days from the date of service, all balances must be paid regardless of insurance payment. In the event that collection procedures are necessary, the patient will be responsible for collection and court cost. I authorize the use of this signature on all insurance claims. I authorize digital images of my teeth to be utilized in any media form in the event that my case will benefit the education of another patient or public.

_____

Signature of patient or parent if minor Date

Payment is due in full at time of treatment unless prior arrangements have been approved.