Please Print
ADULT HEALTH RECORD

POCONO DENTAL ASSOCIATES

Date: _____

Birth Date: _____
Age: _____ Gender_____

Name: _____

Mailing Address: _____
Street City State Zip

Phone: _____ _____ _____
Home Business Cell

Employer: _____ Occupation: _____

Business Address: _____

Marital Status: Single___ Married___ Separated___ Widowed___ Divorced_____

Name of Spouse:_____ Spouse Birth Date:_____

Spouse's Employer: _____

Spouse's Occupation: _____ Business Phone: _____

Who may we contact in the case of an emergency?_____ Phone:_____

Referred By: _____

Who is financially responsible for this bill? _____

Social Security Number: Patient _____ Spouse_____

Dental Insurance: Company: _____ Policy Number: _____

Spouse's Dental Insurance: Company: _____ Policy Number: _____

DENTAL HISTORY

Purpose of visit:_____

Last Dental Visit: Date _____Reason: _____

Circle

Are you having discomfort at this time?_____ Yes No

If so, is there sensitivity to: Hot____ Cold____ Chewing____ Sweet____Swelling____
Do you avoid brushing any part of your mouth because of pain?_____ Yes No
Have you ever had any serious problem associated with previous dental treatment? _____Yes No
If so, please explain:_____

Do your gums bleed while brushing or flossing?_____Yes No
Do your gums feel tender or swollen?_____ Yes No
Do you feel you have bad breath?_____ Yes No
Do your teeth seem to be moving or spreading apart or crowding?_____ Yes No
Have you ever been treated for periodontal disease (gum disease)surgically or non-surgically? _____ Yes No
Do you favor chewing on one side of your mouth? If so, Right_____ or Left _____ Yes No
Do you clench or grind your teeth while sleeping or during the day?_____ Yes No
Do your jaw joints 'pop', 'crack' or cause pain or discomfort?_____ Yes No
Do you wear dentures, partials, orthodontic appliances, or nightguards? _____ Yes No

If so, how do they fit? _____
Type of toothbrush: Soft____ Medium____ Hard____ Electric ____

Continue on back

MEDICAL HISTORY

General Health: Excellent____ Good____ Fair____ Poor___

Name & Address of Physician: _____

_____ Phone: _____

Are you physically or mentally challenged in any way?_____	Yes	No
Are you under the care of a physician now?_____	Yes	No
If so, what for? _____		
Have you ever taken Bisphosphonates or any other medications for osteoporosis or other bone related diseases	Yes	No
Are you taking any medications at the present time?_____	Yes	No
Please list all medications:_____		
Do you have any skin reactions to jewelry?	Yes	No
Do you take any non-prescription drugs daily? (ie:aspirin)_____	Yes	No
If so, which ones?_____		
_____		
Have you ever taken an antibiotic prior to dental visits? _____	Yes	No
Have you been in a hospital during the past 2 years? _____	Yes	No
Have you been under a physician's care within the past 2 years?_____	Yes	No
Do you have, suspect you have, or have had any allergic reaction? (ie:itching, rash, swelling of hands or feet) __	Yes	No
If so, what caused the reaction?(ie: food, medicine, product)_____		
Are you allergic to penicillin?_____	Yes	No
Have you ever had any abnormal bleeding from cuts or extractions requiring special treatment? _____	Yes	No
Do you get short of breath during mild exercise? _____	Yes	No
Have you abnormally lost or gained more than 10 lbs. In the past year?_____	Yes	No
Are you on a special diet?_____	Yes	No
Do you require more than 2 pillows to sleep?_____	Yes	No
Female: Are you pregnant now?_____	Yes	No
Are you taking oral contraceptives?_____	Yes	No

Circle any of the following which you have had or have at present:

Heart Failure	Anemia	Thyroid Disease	Jaundice
Heart Disease/Attack	Stroke	Radiation Therapy	Blood Transfusion
Angina Pectoris	Kidney Trouble	Chemotherapy (Cancer, Leukemia)	Drug /Alcohol Addiction
High Blood Pressure	Ulcers	Venereal Disease (Syphilis,Gonorrhea)	Hemophilia
Emphysema	Rheumatism	Depression	Hearing Impairment
Chronic Cough	Arthritis	Congenital Heart Lesions	Tuberculosis (TB)
Glaucoma	Cold Sores	Bruise Easily	HPV
Asthma	Pain in Jaw Joints	Herpes	Artificial Heart Valve
Hay Fever	HIV Positive	Epilepsy or Seizures	Bleeding Disorder
Heart Pacemaker	Sinus Trouble	AIDS	Fainting or Dizzy Spells
Heart Surgery	Allergies or Hives	Hepatitis—What type? _____	Nervousness
Artificial Joint	Diabetes	Liver Disease	Sickle Cell Disease
Speech or Visual impairment			

Tobacco use of any kind, current or in the past?	Yes	No
Has your doctor ever said you have a cancer or tumor? _____	Yes	No
Do you have any disease, condition or problem not listed on this form? _____	Yes	No

If so, please list it here? _____

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Your signature: _____ Date: _____

Date: _____ Service Rendered: _____

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