Dental Health of Silver Spring

General Dentistry

11 Flowers Drive, Suite 100 Mechanicsburg, Pennsylvania 17050

Telephone: (717) 766-0600
Fax: (717) 766-0668

Patient Information

Patient's Name ______________________
Last First Nickname Middle

Address ______________________
Street City State Zip

Home Phone ____________ Cell Phone ____________ Work Phone ____________

Birthdate ____________ Social Security # ____________

If patient is a minor, give parent's or guardian's name ______________________

Whom may we thank for referring you to our office ______________________

Responsible Party Information

Name ______________________ ____________
Last First Middle Marital Status

Residence ______________________
Street City State Zip

Mailing Address ______________________
Street City State Zip

How long at this address ____________ Home Phone ____________ Work Phone ____________

Previous Address (if less than 3 years) ______________________
Street City State Zip

Social Security # ____________ Birthdate ____________ Relationship to Patient ____________

Employer ____________ Occupation ____________ No. of Years Employed ______

Employer Address ______________________ Employer Phone ____________

Spouse's Name ______________________
Last First Middle

Spouse's Employer ______________________

Occupation ______________________ Work Phone ____________

Dental Insurance Information

Insured's Name ______________________ Insured's Social Security # ____________

Insurance Company ______________________ Group No. ____________

Insurance Company Address ______________________

Does your spouse have separate coverage? ☐ Yes ☐ No If yes:

Insured's Name ____________

Insurance Company ______________________ Group No. ____________

Insurance Company Address ______________________

Insured's Employer ______________________

Emergency Information

Person to contact in case of emergency ______________________

Complete Address ______________________

Phone (day) ______________________ (night) ______________________

Signature (parent's signature if minor) ______________________

Health Information

1. Are you having pain or discomfort at this time?..................YES NO
2. Are you having pain in jaw joints? ....YES NO
3. Do you feel nervous about having dental treatment? ....YES NO
4. Have you ever fainted in a dental office?.............................YES NO
5. Have you ever had a bad experience in the dental office?...YES NO
6. Have you been hospitalized during the past two years? ......YES NO
7. Have you been under the care of a medical doctor during the past two years?.....YES NO

   Physician's Name________________________Phone Number____________________

   Physician's Address____

8. Are you taking any medication, drugs or pills? .....YES NO

   If yes, please list

9. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? .....YES NO
10. Indicate which of the following you have had or have at present. Circle "YES" or "NO" to each item.

Heart Disease or Attack	YES	NO	Cough	YES	NO	Hepatitis A (infectious)	YES	NO
Angina Pectoris	YES	NO	Tuberculosis (TB)	YES	NO	Hepatitis B (serum)	YES	NO
High Blood Pressure	YES	NO	Asthma	YES	NO	Hepatitis C (non A, B)	YES	NO
Heart Murmur	YES	NO	Tobacco Use	YES	NO	Blood Transfusion	YES	NO
Artificial Heart Valve	YES	NO	Hay Fever	YES	NO	Hemophilia	YES	NO
Heart Pacemaker	YES	NO	Sinus Trouble	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Allergies or Hives	YES	NO	Liver Disease	YES	NO
Artificial Joints (Hip, Knee)	YES	NO	Diabetes	YES	NO	Yellow Jaundice	YES	NO
Orthopedic Surgery	YES	NO	Thyroid Disease	YES	NO	Drug Addiction	YES	NO
Stroke	YES	NO	Radiation or Cobalt Treatment	YES	NO	Cold Sores (fever sores)	YES	NO
Rheumatic Fever	YES	NO	Chemotherapy (cancer, leukemia)	YES	NO	Epilepsy or Seizures	YES	NO
Congenital Heart Lesions	YES	NO	Arthritis	YES	NO	Fainting or Dizzy Spells	YES	NO
Scarlet Fever	YES	NO	Rheumatism	YES	NO	Nervousness	YES	NO
Anemia	YES	NO	Cortisone Medicine or Injection	YES	NO	Psychiatric Treatment	YES	NO
Kidney Trouble	YES	NO	Glaucoma	YES	NO	Bruise Easily	YES	NO
Ulcers	YES	NO	A.I.D.S.	YES	NO	Cosmetic Surgery	YES	NO
Emphysema	YES	NO	HIV Positive	YES	NO			

11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?.....YES NO
12. Do your ankles swell during the day?................................YES NO
13. Do you use more than 2 pillows to sleep?..........................YES NO
14. Have you lost or gained more than 10 lbs. in the past year?YES NO
15. Have you ever taken antibiotics before a dental appointment?....YES NO
16. Are you pregnant YES NO If yes, what month are you due?______________ Are you taking birth control pills? YES NO
17. Are you on a special diet? .....YES NO
18. Do you bleed excessively when cut?.....YES NO
19. Has your medical doctor ever said you have cancer or a tumor? .....YES NO
20. Do you have any disease, condition or problem not listed? .YES NO
21. Is there any other information concerning your health that we should know about? .....YES NO

I hereby authorize the clinical dental staff to perform for me and/or my dependents such dental treatment, medication or therapy as they deem appropriate and in connection therewith to take or prepare x-rays, models or other diagnosis aids. I acknowledge that the performance of dental services (especially in the use of anesthetic) inherently involves some risk.

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependent is mine, due and payable at the time services are rendered.

I agree to pay interest on any late payment at the rate of 1 1/2% per month. In the event my account is turned over to an attorney for collection, I agree to pay legal fees in the amount of 33 1/3% of the outstanding balance plus all court costs.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered truthfully and to the best of my knowledge.

Patient ______________________________ Date ______________

Parent or Responsible Party ______________________ Relationship to Patient ______________

Medical Updates (office use only)

Date	Exceptions	New Medicines		Patient's Signature
			None ☐	
Date	Exceptions	New Medicines		Patient's Signature
			None ☐	
Date	Exceptions	New Medicines		Patient's Signature
			None ☐	
Date	Exceptions	New Medicines		Patient's Signature
			None ☐	