759 Newtown-Yardley Road
Newtown, PA 18940

REGISTRATION & HEALTH HISTORY

Date ____

First Name ___________________________________ M.I. ______ Last Name ____

❑ Male ❑ Female Date of Birth ____ Current Age ___________________________________

Address____ City _____________________ State _______ ZIP ________________

Email ____ Emergency Contact ____________________________

What would you prefer to be called (name)? ___________________ Who may we thank for your referral? ____________________________

Marital Status ❑ Married ❑ Single Student ❑ Full-time ❑ Part-time ❑ N/A Occupation ____

Primary Care Physician____Physician's Phone ____

Dental Insurance Carrier _________________________________ Policy ID # ______________________________ Group # _______________

❑ Check this box *ONLY* if the insured person (the one receiving dental service) is the same as applicant above. If not, enter Insured info below.

Name of Insured ——————————————————— Insured's SS# _______________________ Insured's DOB _______________

Relationship to Insured ____

Employer of Insured ____________________________________ ❑ Full-Time ❑ Part-time ❑ Retired Phone __________________________

Employer Address ______________________________________ City _____________________________ State _____ ZIP _______________

Who is financially responsible for this account? ____ Phone ________________

Please select Y = YES or N = NO if you have any of the following conditions:

❑ Y ❑ N – Rheumatic Fever
❑ Y ❑ N – Heart Disease
❑ Y ❑ N – Heart Murmur (or MVP)
❑ Y ❑ N – High Blood Pressure
❑ Y ❑ N – Tuberculosis
❑ Y ❑ N – Use oral contraceptives?
❑ Y ❑ N – Artificial Joint / Heart Valve
❑ Y ❑ N – History of Endocarditis
❑ Y ❑ N – Thyroid Disease
❑ Y ❑ N – Anemia
❑ Y ❑ N – Asthma
❑ Y ❑ N – Diabetes
❑ Y ❑ N – Are you nursing?
❑ Y ❑ N – Might you be pregnant?
❑ Y ❑ N – Hepatitis Type: ❑ A ❑ B ❑ C
❑ Y ❑ N – Radiation Therapy: Head/Neck
❑ Y ❑ N – Seizure Disorder
❑ Y ❑ N – Kidney Disease
❑ Y ❑ N – Venereal Disease
❑ Y ❑ N – Bleeding Problems
❑ Y ❑ N – Cancer
❑ Y ❑ N – AIDS / HIV
❑ Y ❑ N – Easting Disorder(s)
❑ Y ❑ N – History of HPV

Other conditions not listed:

Are you allergic to latex, soy, egg, milk, dairy or nut products? ____

List any antibiotics, anasthetics or other drugs you are allergic to ____

List all prescription/OTC medications, vitamins and/or supplements you presently take ____

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DO you have any disease, organ transplant, or take any medication that may suppress your immune system? ___________________________

DO you have, or have you ever had, clicking, popping or pain in your temporomandibular joints (TMJ)? ______________________________

Have you been hospitalized in the past five years? ❑ Y ❑ N – If so, why? ____

Are you currently under a physician's care? ❑ Y ❑ N – If so, why? ____

Do you take aspirin on a daily basis? ❑ Y ❑ N – If so, how much and why? ____

Have you ever been a substance abuser? ❑ Y ❑ N ____

Do you smoke or use smokeless tobacco products? ❑ Y ❑ N If so, how much / how frequently? ___________________________________

Is there anything you would like to discuss with the doctor in private? ____

I understand and answered the above questions honestly and completely. I understand the doctor is basing his treatment on this information. I authorize the release of information to insurance carriers and health professionals involved in my care. I assign my insurance benefits to the doctor unless otherwise indicated.

Signature* ____ **Date** ___________________________________

**Your signature indicates you have received a copy of the HIPAA law and Dental Materials forms, as well as releasing the doctor to utilize any dental photographs for lecturing and educational purposes.*