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 Broomall, PA 19008
 (610)356-8011

Chart #: _____
 FOR OFFICE USE ONLY

Patient Information			
Patient Name: _____		Date: _____	
Last	First	MI	
Address: _____			
Street			Apartment #
City	State	Zip Code	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Family Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Child <input type="checkbox"/> Other _____		
Social Security #: _____		Birth Date: _____	
Phone (Home): _____		(Work): _____ Ext: _____ Email: _____	
Preferred appointment times: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Any Time <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T			

Health Information	
Date of Last Dental Visit: _____	Reason for this visit: _____
Last Dental X-Ray's : _____	Full Set or BiteWings _____ Last Dental Cleaning: _____

Have you ever had any of the following? Please check those that apply: _____

- AIDS or HIV
- Allergies _____
- Anemia
- Arthritis
- Artificial Joints
- Asthma
- Blood Disease
- Cancer
- Diabetes
- Dizziness
- Epilepsy

- Emphysema
- Fainting
- Glaucoma
- Growths
- Hay Fever
- Head Injuries
- Heart Disease
- Heart Murmur
- Hepatitis
- High Blood Pressure
- Jaundice
- Kidney Disease
- Liver Disease

- Mental Disorders
- Mitral Valve Prolapse
- Nervous Disorders
- Pacemaker
- Pregnancy
Due date: _____
- Radiation Treatment
- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Sinus Problems
- Stomach Problems

- Stroke
- Tuberculosis
- Tumors
- Ulcers
- Venereal Disease
- Codeine Allergy
- Penicillin Allergy
- OTHER:

- _____

- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Are you currently taking any medications? Yes No
If yes, please list: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Referral Information	
Whom may we thank for referring you to our practice? <input type="checkbox"/> Another patient, friend <input type="checkbox"/> Another patient, relative	
<input type="checkbox"/> Dental Office <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Newspaper <input type="checkbox"/> School <input type="checkbox"/> Work <input type="checkbox"/> Other _____	
Name of person or office referring you to our practice: _____	