2431 Easton Avenue, Bethlehem, Pa 18017 (610)861-0190
1050 S. Cedar Crest Blvd., Suite 104 Allentown, Pa 18104 (610)973-2090

ADULT/CHILD PATIENT MEDICAL INFORMATION

Patient's Name_____

	Yes	No		Yes	No
Joint Replacement	___	___	High Blood Pressure		___
Heart Murmur	___	___			
Mitral-Valve Prolapse	___	___	Low Blood Pressure	___	___
Pregnancy/Nursing	___	___	Nervous Disorder		___
Smoker	___	___			
Rheumatic Fever	___	___	Epilepsy		___
Aids or HIV test (+pos)	___	___			
Hepatitis	___	___	Diabetes		___
Venereal Disease	___	___			
Bronchitis		___	Stroke	___	___
			Cancer	___	___
Asthma		___	Hay Fever	___	___
			Anemia	___	___
Tuberculosis	___	___	Radiation Therapy	___	___
Kidney Disease	___	___	Leukemia	___	___
Thyroid Disease		___	Blood Disease	___	___
			Liver Disease	___	___
Heart Trouble		___			

If you had **a joint replacement**, please list date of surgery and the name and phone number of the Physician

_____

****Are there any other conditions that may be important to your care? *****

_____

Is the patient under the care of a physician at this time or within the last 2 years?
If so, for what?

_____

Has the patient been hospitalized within the past 2 years?
If so, for what?

_____

Have you had an Allergic Reaction to any medication (itching, swelling, hives etc?) If so, what medication?

_____

Are you currently taking any medications? If so, please list:

_____
_____
_____
_____
_____
_____
_____
_____

Permission is hereby granted to perform any necessary dental work and authorize my insurance company to pay the dentist or dental group all insurance benefits. I also understand that (regardless of my insurance status), I am responsible for the balance on this account for any and all services rendered to me or my dependents. I certify that this information is true and correct to my knowledge. I will notify you of any changes in my health or the information above.

Signature_____Date_____
_

Print
Name_____

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PLEASE→