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**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 \_\_\_ \_\_\_***

***Heart Murmur \_\_\_ \_\_\_***

**Mitral-Valve Prolapse \_\_\_ \_\_\_**

**Pregnancy/Nursing \_\_\_ \_\_\_**

***Smoker \_\_\_ \_\_\_***

**Rheumatic Fever** \_\_\_ \_\_\_

***Aids or HIV test (+pos) \_\_\_ \_\_\_***

**Hepatitis \_\_\_ \_\_\_**

Venereal Disease \_\_\_ \_\_\_

Bronchitis \_\_\_ \_\_\_

Asthma \_\_\_ \_\_\_

Tuberculosis \_\_\_ \_\_\_

Kidney Disease \_\_\_ \_\_\_

Thyroid Disease \_\_\_ \_\_\_

Heart Trouble \_\_\_ \_\_\_

High Blood Pressure \_\_\_ \_\_\_

Low Blood Pressure \_\_\_ \_\_\_

Nervous Disorder \_\_\_ \_\_\_

Epilepsy \_\_\_ \_\_\_

Diabetes \_\_\_ \_\_\_

Stroke \_\_\_ \_\_\_

Cancer \_\_\_ \_\_\_

Hay Fever \_\_\_ \_\_\_

Anemia \_\_\_ \_\_\_

Radiation Therapy \_\_\_ \_\_\_

Leukemia \_\_\_ \_\_\_

Blood Disease \_\_\_ \_\_\_

Liver Disease \_\_\_ \_\_\_

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

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\*\*\*\*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:

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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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