Doylestown Dental Solutions P.C.

FAMILY, COSMETIC and IMPLANT DENTISTRY

We are complimented that you have selected us to provide dental care for you and your family.

Whom may we thank for referring you to our office? _____

Patient Information

Today's Date_____ Patient's Date of Birth_____

Patient's Last Name_____First Name_____MI_____

Complete Address_____

Home Phone _____ Work _____ Cell_____

Patient's Social Security #_____

Email_____

If patient is a minor, give parent/guardian's name _____

Emergency Contact Name/Relationship _____

Responsible Party Information

Last Name_____First Name_____MI _____

Billing Address_____

Home Phone _____ Work _____ Cell_____

Social Security #_____DOB_____

Relationship to patient _____

Employer_____

Employer Address _____

Dental History

Date of last dental examination_____What was done at that time? _____

Former Dentist Name_____Phone_____

Address_____

Are you having any pain or discomfort at this time? ❑ YES ❑ NO If yes, please describe:_____

Medical History Information

Physician Name_____Phone_____

Address_____

Are you now or have you been recently under treatment by a physician ❑ YES ❑ NO

If so, describe: _____

Date of last physical examination _____

Have you ever had any serious illnesses, operation or hospitalization? ❑ YES ❑ NO

If so, describe _____

Do you smoke or chew tobacco? ❑ YES ❑ NO

Do you consume alcohol? ❑ YES ❑ NO

Do you have or have you had any drug addictions? ❑ YES ❑ NO

Women Only: Are you pregnant or nursing? ❑ YES ❑ NO

Medical History Information (continued)

Do you have any allergies? (Medications, anesthetics, latex, metals, etc.) ❑ YES ❑ NO If YES, please list.

_____

Do you have or have you had any of the following:

- ❑ Heart Failure
- ❑ Heart Disease
- ❑ Heart Attack
- ❑ Angina Pectoris
- ❑ Congenital Heart Disease
- ❑ Heart Murmur
- ❑ High Blood Pressure
- ❑ Arteriosclerosis
- ❑ Mitral Valve Prolapse
- ❑ Artificial Heart Valve
- ❑ Heart Pacemaker
- ❑ Heart Surgery
- ❑ Stroke
- ❑ High Cholesterol
- ❑ Rheumatic Fever
- ❑ Hemophilia
- ❑ Anemia
- ❑ Blood Transfusion
- ❑ Glaucoma
- ❑ Kidney Disease
- ❑ Ulcers
- ❑ Acid Reflux/GERD
- ❑ GI Trouble or Disease
- ❑ Diabetes (Type I, Type II, or Gestations) $HbA^1C\%$____
- ❑ Tumors
- ❑ Cancer
- ❑ Radiation Therapy
- ❑ Chemotherapy
- ❑ Thyroid Problems
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ Liver Disease
- ❑ Sexually Transmitted Disease
- ❑ HIV or AIDS
- ❑ Cold Sores or Fever Blisters
- ❑ Lung Disease
- ❑ Emphysema
- ❑ Chronic Cough
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Hay Fever
- ❑ Sinus Trouble
- ❑ Artificial joints (hip, knee, etc.)
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Osteopenia or Osteoporosis
- ❑ Fainting or Dizziness
- ❑ Epilepsy or Seizures
- ❑ Mental Health Disorders (please explain)
- ❑ Special Needs or Disabilities

Other Conditions not listed:

_____

_____

_____

Are you taking any anticoagulants, blood thinners or aspirin? ❑ YES ❑ NO INR#_____

Please list all medications you are currently taking including prescription, herbal supplements, and over-the-counter:

_____

_____

_____

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

Patient Signature_____Date _____

Consent:

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with **(name of patient)**_____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a $1\ ^1/_2$ % finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that is it my responsibility to advise your office of any changes in the information contained on this form.

Patient signature_____Date_____Witness _____

_____

Office Use Only –Interim Update:

Patient Signature_____Date_____Patient Signature_____Date_____
Patient Signature_____Date_____Patient Signature_____Date_____
Patient Signature_____Date_____Patient Signature_____Date_____
Patient Signature_____Date_____Patient Signature_____Date_____