



**Prosthodontics Intermedica**  
 467 Pennsylvania Avenue  
 Fort Washington, PA 19034 USA  
 (215) 646-6334 Office  
 (215) 643-1149 Fax

**PINK MED HISTORY FORM 1/10**

Today's Date: \_\_\_\_\_  
 Box Number: \_\_\_\_\_  
 Age: \_\_\_\_\_  
 Fax Number: \_\_\_\_\_  
**PHARMACY PHONE:** \_\_\_\_\_

**Confidential Medical History Record**

Name \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

I prefer to be addressed on correspondence as \_\_\_\_\_ in person \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Driver's License # \_\_\_\_\_

Residence Address \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Marital Status: Married [ ] Divorced [ ] Single [ ]  
 Separated [ ] Widowed [ ] Engaged [ ]

Social Security Number \_\_\_\_\_ Birth date \_\_\_\_\_ Res. Phone (\_\_\_\_) \_\_\_\_\_  
(mo) (day) (yr)

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Bus. Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Bus. Phone (\_\_\_\_) \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Guarantor \_\_\_\_\_

**Where did you learn about us? (Check All That Apply)**

- Internet
- US Airways Magazine
- New Beauty Magazine
- Radio Advertisement
- Yellow Pages
- Your General Dentist: \_\_\_\_\_
- Other: \_\_\_\_\_

**Whom may we thank for referring you?**

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

**Did you visit our website? Yes [ ] No [ ]**

Personal Physician	Telephone
Address	

General Dentist	Telephone
Address	

**Have you ever been treated by any of the following?**

Endodontist	Treatment Date
Address	

Oral Surgeon	Treatment Date
Address	

Orthodontist	Treatment Date
Address	

Cardiologist	Treatment Date
Address	

Periodontist	Treatment Date
Address	

Prosthodontist	Treatment Date
Address	

Otolaryngologist (Ear, Nose, Throat)	Treatment Date
Address	

Plastic Surgeon	Treatment Date
Address	

(Please complete all sides)

(Continued on next page)

Signature \_\_\_\_\_

Date \_\_\_\_\_

O	Neurologist Address	Treatment Date	O	Dermatologist Address	Treatment Date
	Endocrinologist Address	Treatment Date		Psychiatrist/Psychologist Address	Treatment Date
	Other Specialist (Please Specify) Address			Other Specialist (Please Specify) Address	Treatment Date

Name of contact person: \_\_\_\_\_ Relationship \_\_\_\_\_  
(To be contacted in case of emergency)

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell(\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Please *briefly* describe your current condition or problem that prompted this visit.

**Medical History**

**Blood Pressure**  /

1. Are you in good health? Yes [ ] No [ ]
2. Date of last physical examination \_\_\_\_\_ by Dr. \_\_\_\_\_  
(mo) (day) (yr) (if other than family physician)
3. Are you now under the care of a physician? Yes [ ] No [ ]  
 If yes, who and what is the condition being treated?  
 Doctor \_\_\_\_\_ Condition \_\_\_\_\_
4. Have you ever had any serious illness or operation? Yes [ ] No [ ]  
 If yes, what illness or operation? \_\_\_\_\_  
 Date \_\_\_\_\_ Location \_\_\_\_\_ Doctor \_\_\_\_\_  
(mo/yr)
5. Have you ever been hospitalized? Yes [ ] No [ ]  
 If yes, why? \_\_\_\_\_  
 Date \_\_\_\_\_ Hospital \_\_\_\_\_ Doctor \_\_\_\_\_  
(mo/yr)
6. Are you currently taking antibiotics or any drugs or medication? Yes [ ] No [ ]  
 Antibiotics Yes [ ] No [ ] If yes, what? \_\_\_\_\_  

	dosage	prescribing doctor	reason for use
Nitroglycerin Yes [ ] No [ ]	_____	_____	_____
Hormone Replacement Therapy Yes [ ] No [ ]	_____	_____	_____
Thyroid Medication Yes [ ] No [ ]	_____	_____	_____
If yes, year prescribed _____	_____	_____	_____
Aspirin Yes [ ] No [ ]	_____	_____	_____
If yes, how many daily? _____	_____	_____	_____
Pain Medication Yes [ ] No [ ]	_____	_____	_____
If yes, What? _____	_____	_____	_____

Do you have any disease, condition or problem not listed above that you think I should know about? If yes, please explain \_\_\_\_\_ Yes [ ] No [ ]

Signature \_\_\_\_\_ Date \_\_\_\_\_

Sedatives or Sleeping Pills? Yes [ ] No [ ]

If yes, how many per day? \_\_\_\_\_

\_\_\_\_\_ dosage \_\_\_\_\_ prescribing doctor \_\_\_\_\_ reason for use

Have you ever taken FEN-PHEN? Yes [ ] No [ ] Have You taken MERIDIA Yes [ ] No [ ]

If yes, \_\_\_\_\_ prescribing doctor \_\_\_\_\_ Cardiologist evaluation Yes [ ] No [ ]  
 Cardiologist: \_\_\_\_\_

Have you ever taken: Aredia \_\_\_\_\_ Zometa \_\_\_\_\_ Fosamax \_\_\_\_\_ Actonel \_\_\_\_\_ Boniva \_\_\_\_\_  
 Dosage \_\_\_\_\_ number of years \_\_\_\_\_ prescribing doctor \_\_\_\_\_ reason for use \_\_\_\_\_

Please list any additional medications and reason for use:

Medication \_\_\_\_\_ dosage \_\_\_\_\_ prescribing doctor \_\_\_\_\_ reason for use

Medication \_\_\_\_\_ dosage \_\_\_\_\_ prescribing doctor \_\_\_\_\_ reason for use

7. Are you sensitive or allergic to any medications? Yes [ ] No [ ]

Penicillin Yes [ ] No [ ] Sulfa Drugs Yes [ ] No [ ]

Tetracycline Yes [ ] No [ ] Codeine Yes [ ] No [ ]

8. Have you ever had penicillin? Yes [ ] No [ ]

Do you have or have you ever had any of the following?

Y	N	Conditions	Y	N	Conditions	Y	N	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes - Insulin Dependent	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/ HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes - Oral Medication	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing/Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Allergies or Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis or Osteopenia
<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Joint Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems/Nervous Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia or Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment
<input type="checkbox"/>	<input type="checkbox"/>	Other Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Ailments/ Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Bacterial Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Gastrointestinal Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, liver disease (A/B/C)	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Burning Tongue	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid or Parathyroid disease
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy - I.V. -Aredia	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or growth
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy - I.V. -Zometa	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems/Disease/Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Xerostomia (Dry Mouth)
<input type="checkbox"/>	<input type="checkbox"/>	Cosmetic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	

10. Do you have any tattoos or body piercing? YES [ ] No [ ] Location? \_\_\_\_\_

11. Does exposure to the sun cause you to break out? YES [ ] NO [ ] 12. Do you wear contact lenses? Yes [ ] No [ ]

13. Do you have any Biomedical or tissue implants such as:

Chin  Breast  Dental  Knee  Hip  Heart Valve  Craniofacial  Other

Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ (Continued on next page)

- 14. Do you use tobacco? [ ] Cigarette [ ] Pipe [ ] Cigar [ ] chewing tobacco? If so, how much? \_\_\_\_\_ Yes [ ] No [ ]
- 15. Do you use alcohol? If so, how much? \_\_\_\_\_ Yes [ ] No [ ]
- 16. Do you use drugs? If so, what type and how much? \_\_\_\_\_ Yes [ ] No [ ]
- 17. Have you traveled abroad recently or had any health related symptoms after traveling abroad? Yes [ ] No [ ]
- 18. Have you spent any extended period of time in foreign countries?  
(Peace Corps, military travel, etc.). Yes [ ] No [ ]
- 19. Have you ever experienced diarrhea for extended periods of time? (2 to 3 months) Yes [ ] No [ ]
- 20. (Women) Are you pregnant? Yes [ ] No [ ]
- 21. (Women) Do you have any problems associated with your menstrual period? Yes [ ] No [ ]
- 22. (Women) Are you going through menopause now or have you in the past? Yes [ ] No [ ]  
Please indicate stage: Now [ ] In past [ ] Year started \_\_\_\_\_ Completed \_\_\_\_\_

**Dental History**

- 1. Have you ever had a local anesthetic? (Novacaine, etc.) Yes [ ] No [ ]
- 2. Have you ever had an unfavorable reaction to a local anesthetic? Yes [ ] No [ ]
- 3. Have you had any serious trouble associated with any previous dental treatment? Yes [ ] No [ ]
- 4. How long since your last x-ray? \_\_\_\_\_
- 5. How long since your last dental treatment ? \_\_\_\_\_)
- 6. Does dental treatment make you nervous? Yes [ ] No [ ]
- 7. Have you ever had Nitrous Oxide Analgesia (gas) during dental treatment? Yes [ ] No [ ]

**Dental Insurance Information: If so, do you have more than one provider? Yes \_\_\_ No \_\_\_**

- 1. Do you have dental insurance? Yes [ ] No [ ]  
If yes: Name of Primary Carrier \_\_\_\_\_  
Address \_\_\_\_\_  
Group Insurance No. \_\_\_\_\_ ID # \_\_\_\_\_
- 2. Do you have medical insurance? Yes [ ] No [ ]  
If yes: Name of Primary Carrier \_\_\_\_\_  
Address \_\_\_\_\_  
Group Insurance No. \_\_\_\_\_ ID # \_\_\_\_\_
- 3. Is your treatment accident related? Yes [ ] No [ ]  
If yes: Date of Accident \_\_\_\_\_  
Attorney handling the accident \_\_\_\_\_  
(name) (phone number)

**CONSENT FOR TREATMENT** I hereby authorize any treatment necessary as related to the dental care of the patient whose name appears on this health history form and grant authority to administer such anesthetics, analgesics, sedatives and nitrous oxide sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I understand that there are possible adverse effects of the procedures, anesthetics and/or drugs to be employed. I consent to photographs filming, recording, and x-rays of my oral and facial structures and their publication and the observation by additional professional staff for educational and scientific purposes. My name will not be revealed without my consent. I am aware that Prosthodontics Intermedica is NOT a Participating Provider with any dental, medical, or health insurance company, including Medicare and Medicaid. I am also aware and understand that I am fully responsible for all financial aspects of any services and treatment I receive.

Even though Prosthodontics Intermedica does not accept insurance for its services and treatment, Prosthodontics Intermedica may submit a claim to my insurance company on my behalf at my request, in an effort to assist in obtaining insurance reimbursement directly to me. It is understood that even with this courtesy, it is my responsibility to pay for all financial aspects of any services and treatment I receive.

**\*\*You are ultimately responsible for payment of any outstanding balance.\*\* After (120) days from treatment, delinquent accounts will be turned over to a professional agency for collection. In addition, charges related to the cost of collection (including but not limited to collection agency fees, reasonable attorney fees, and court costs) will be added to your account.**

**Failure to provide at least 24 hours notice of appointment cancellation will result in a cancellation fee. \_\_\_\_\_ INITIAL**

Signature \_\_\_\_\_ Date \_\_\_\_\_ Medical History Form.doc 4/10