



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

PINK MED HISTORY FORM 2/12

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 (____) _____

Occupation _____

Spouse's Employer _____ Bus. Phone (____) _____

Address _____ 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 []

<input type="checkbox"/> Personal Physician	Telephone
Address	

<input type="checkbox"/> General Dentist	Telephone
Address	

Have you ever been treated by any of the following?

<input type="checkbox"/> Endodontist	Treatment Date
Address	
<input type="checkbox"/> Oral Surgeon	Treatment Date
Address	
<input type="checkbox"/> Orthodontist	Treatment Date
Address	
<input type="checkbox"/> Cardiologist	Treatment Date
Address	

<input type="checkbox"/> Periodontist	Treatment Date
Address	
<input type="checkbox"/> Prosthodontist	Treatment Date
Address	
<input type="checkbox"/> Otolaryngologist (Ear, Nose, Throat)	Treatment Date
Address	
<input type="checkbox"/> Plastic Surgeon	Treatment Date
Address	

(Please complete all sides)

Signature _____

Date _____

<input type="checkbox"/>	Neurologist Address	Treatment Date	<input type="checkbox"/>	Dermatologist Address	Treatment Date
<input type="checkbox"/>	Endocrinologist Address	Treatment Date	<input type="checkbox"/>	Psychiatrist/Psychologist Address	Treatment Date
<input type="checkbox"/>	Other Specialist (Please Specify) Address		<input type="checkbox"/>	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

	/	
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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? _____

Nitroglycerin Yes [] No []

dosage	prescribing doctor	reason for use
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hormone Replacement Therapy Yes [] No []

dosage	prescribing doctor	reason for use
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Thyroid Medication Yes [] No []

dosage	prescribing doctor	reason for use
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If yes, year prescribed _____

dosage	prescribing doctor	reason for use
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Aspirin Yes [] No []
 If yes, how many daily? _____

dosage	prescribing doctor	reason for use
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pain Medication Yes [] No []

If yes, What? _____

dosage	prescribing doctor	reason for use
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any disease, condition or problem not listed above that you think I should know about? Yes [] No []

If yes, please explain _____

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

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 _____

- 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 Tooth Whitening (Bleaching)? When? _____ Yes [] No []
- 8. 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 2/12