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

Today's Date _____

Box Number _____

PHARMACY PHONE _____

Confidential Medical History Record

Name _____ **EMAIL ADDRESS** _____

I prefer to be addressed in person as _____ Driver's License #_____

Residence Address _____ Cell Phone (___)_____

City, State, Zip Code _____

Social Security Number _____ Birth date _____ Home Phone (___)_____

Employer _____ Occupation _____

Address _____ Business Phone (____)_____

Marital Status Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Engaged ☐ Spouse's Name _____

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

Address _____

Guarantor _____ Phone (____)_____

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

☐ Internet ☐ Radio
☐ Magazine ☐ Television
☐ Your Dentist _____
☐ Other _____

Whom may we thank for referring you?

Name _____

Address _____

Phone (____)_____Email _____

Personal Physician Address	Telephone
Other Doctor/Dentist Relevant to Treatment Address	Telephone

General Dentist Address	Telephone
Other Doctor/Dentist Relevant to Treatment Address	Telephone

Name of contact person _____ Relationship _____
(To be contacted in case of emergency)

Home Phone (____)_____ Work Phone (____)_____ Cell(____)_____

Address _____

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

_____

Medical History **Pulse** _____ **Blood Pressure** _____/_____

1. Are you in good health? Yes ☐ No ☐
2. Date of last physical examination _____ by Dr. _____
3. Are you now under the care of a physician? Yes ☐ No ☐
   If yes, who is your doctor and what condition is being treated? Doctor_____ Condition _____
4. Have you ever had any serious illness or operation? Yes ☐ No ☐
   If yes, what illness or operation? _____ Date _____ Doctor _____

Initial____

5. **List any other medications that you are taking**

Check	Name of Medication	Reason for Use	# Per Day	Dosage	# of Years Taken	Prescribing Doctor
☐						
☐						
☐						
☐						

6. Have you ever had penicillin? Yes ☐ No ☐

7. Are you allergic or sensitive to any medications? Yes [ ] No [ ] Please list them: _____

8. **Do you have, or have you ever had, any of the following conditions?**

Y	N	Conditions	Y	N	Conditions	Y	N	Conditions
☐	☐		☐	☐	Fainting spells	☐	☐	Psychiatric /Nervous Disorder
☐	☐	AIDS/ HIV Positive	☐	☐	Fever Blisters	☐	☐	Radiation treatment
☐	☐	Alcohol Dependence	☐	☐	Frequent Headaches	☐	☐	Respiratory disease
☐	☐	Allergies or Hay Fever	☐	☐	Head Injuries	☐	☐	Rheumatism
☐	☐	Alzheimer's Disease	☐	☐	Heart Ailments	☐	☐	Sickle Cell Anemia
☐	☐	Anorexia or Bulimia	☐	☐	Hepatitis, liver disease (A/B/C)	☐	☐	Sinus trouble
☐	☐	Arthritis	☐	☐	High blood pressure	☐	☐	Stomach/Gastrointestinal Disorders
☐	☐	Blood Disorders	☐	☐	Intestinal Disease	☐	☐	Stroke
☐	☐	Burning Tongue	☐	☐	Kidney Problems/Disease/Dialysis	☐	☐	Thyroid or Parathyroid disease
☐	☐	Cancer	☐	☐	Latex Allergy	☐	☐	Tumors or growth
☐	☐	Chemotherapy	☐	☐	Leukemia	☐	☐	Ulcers
☐	☐	Cosmetic Surgery	☐	☐	Lung Disease	☐	☐	Xerostomia (Dry Mouth)
☐	☐	Diabetes	☐	☐	Mitral valve prolapse	☐	☐	Sleep Problems
☐	☐	Drug Dependency	☐	☐	**Osteoporosis or Osteopenia**	☐	☐	Other: _____
☐	☐	Epilepsy/Seizures	☐	☐	Prosthetic Joint Replacement			_____

9. If yes to any of the above, please explain _____

_____

10. Tobacco use ☐ Cigarette ☐ Pipe ☐ Cigar ☐ Chewing tobacco? Quantity _____ Years_____ Yes ☐ No ☐

When? Currently_☐__ In the past _☐__ How long since last used? _____

11. Do you use alcohol? If so, how much? _____ Yes ☐ No ☐

12. Have you traveled abroad recently or had any health related symptoms after traveling abroad? Yes ☐ No ☐

13. Do you drink soda pop? If so, how much? _____ per day _____ brand Yes ☐ No ☐

14. (Women) Are you pregnant? Yes ☐ No ☐

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 dental x-ray? _____
5. How long since your last dental treatment? _____
6. Does dental treatment make you nervous? Yes ☐ No ☐
8. Have you ever had Nitrous Oxide Analgesia (gas) during dental treatment? Yes ☐ No ☐
7. Have you ever had general anesthesia for medical / dental treatment? When? _____ Yes ☐ No ☐

Please provide any other relevant information

_____

_____

_____

Dental Insurance Information Do you have dental insurance? Yes ☐ No ☐ If so, do you have more than one provider? Yes ☐ No ☐

Dental Insurance-

Primary Dental Insurance Company Address_____
Name of Policy Holder_____ Policy Holder's Date of Birth_____
Policy Holder's SS#_____ Group Number _____ ID# _____
Name of Employer _____ Employer's Address_____

Secondary Dental Insurance Company Address_____
Name of Policy Holder_____ Policy Holder's Date of Birth_____
Policy Holder's SS#_____ Group Number _____ ID# _____
Name of Employer _____ Employer's Address_____

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 48 hours' notice of appointment cancellation will result in a cancellation fee. _____***INITIAL***

Signature of Patient or Guarantor_____ **Date** _____