Innovative Dentistry of Valley Forge
Health History and Registration Form

Patient Information

Name (FML):			Prefers to be called:
Address:			City/State/Zip:
Home Phone:	Work Phone:	Email:	Cell Phone:
SS#:			Date of Birth:
Sex: M F	Marital status:	Who may we thank for referring you?	
Employment status (circle one): FT PT Retired			Student status (circle): FT PT

Responsible Party Information

Patient is: ❑ Policy holder ❑ Responsible party (*skip to next section*)

Name (FML):		Relationship to patient:
Address:		City/State/Zip:
Home Phone:	Business Phone:	Cell Phone:
SS#:		Date of Birth:

- ❑ Responsible party is also a policy holder for patient
- ❑ Primary insurance policy holder
- ❑ Secondary insurance policy holder

Primary Insurance Information

Name of insured:	
Relationship to patient:	
❑ Self ❑ Child	
❑ Spouse ❑ Other	
Insured SS#:	
Insured date of birth:	
Employer name:	
Address 1:	
Address 2:	
City/State/Zip:	
Phone:	
Insurance company name:	
Group #	
Address 2:	
City/State/Zip:	
Phone:	

Secondary Insurance Information

Name of insured:	
Relationship to patient:	
❑ Self ❑ Child	
❑ Spouse ❑ Other	
Insured SS#:	
Insured date of birth:	
Employer name:	
Address 1:	
Address 2:	
City/State/Zip:	
Phone:	
Insurance company name:	
Group #	
Address 2:	
City/State/Zip:	
Phone:	

How will you be paying for our services?

- ❑ Care Credit account #:
- ❑ Credit card (indicate type, acct #, exp date):
- ❑ Other (indicate):

WHAT IS THE MAIN REASON FOR YOUR VIST?

_____

Patient Dental Information

	Yes	*No*		*Yes*	*No*
Do your gums bleed or feel tender or irritated?	❑	❑	Have you had any periodontal (gum) treatments?	❑	❑
Are you teeth sensitive to hot, cold, sweets or pressure?	❑	❑	Have you ever had orthodontic (braces) treatment?	❑	❑
Do you wear removable dental appliances?	❑	❑	Have you had serious problems associated with any previous dental treatment?	❑	❑
Do you have headaches, earaches or neck pains?	❑	❑	If yes, please explain:		

Date of last dental exam:
Date of last dental x-rays:

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Patient Medical History

Are you under a physician's care now? Y N If yes, please explain:

Date of last physical examination: Physician name:

Physician address: Physician phone:

	Yes	*No*		*Yes*	*No*
1. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain:	❑	❑	6. Are you taking any medication(s) Including non-prescription medicine? If yes, what medication(s) are you taking?	❑	❑
2. Do you use controlled substances?	❑	❑	7. *Women only:* Are you pregnant or think you may be pregnant?	❑	❑
3. Have you ever taken Phen-Fen/ Redux?	❑	❑	Are you nursing?	❑	❑
4. Do you use tobacco?	❑	❑	Are you taking oral contraceptives?	❑	❑

5. Are you allergic or have you had a reaction to any of the following?

	Yes	*No*		*Yes*	*No*
Local Anesthetics	❑	❑	Iodine	❑	❑
Aspirin	❑	❑	Hay fever / seasonal	❑	❑
Penicillin or Other Antibiotics	❑	❑	Animals	❑	❑
Barbiturates, sedatives, or sleeping pills	❑	❑	Acrylic	❑	❑
Sulfa drugs	❑	❑	Food (specify):	❑	❑
Codeine or other narcotics	❑	❑	Other (specify):	❑	❑
Latex	❑	❑	Metals (specify):	❑	❑

Please (x) a response to indicate if you have or have not had any of the following diseases or problems.

	Yes	*No*		*Yes*	*No*		*Yes*	*No*
AIDS / HIV Positive	❑	❑	Excessive Bleeding	❑	❑	Mitral Valve Prolapse	❑	❑
Alzheimer's Disease	❑	❑	Excessive Thirst	❑	❑	Nervousness	❑	❑
Anaphylaxis	❑	❑	Fainting / Dizziness	❑	❑	Pain in Jaw Joints	❑	❑
Anemia	❑	❑	Frequent Cough	❑	❑	Parathyroid Disease	❑	❑
Angina	❑	❑	Frequent Diarrhea	❑	❑	Psychiatric Care	❑	❑
Arthritis / Gout	❑	❑	Frequent Headaches	❑	❑	Radiation Treatment	❑	❑
Artificial Heart Valve	❑	❑	Glaucoma	❑	❑	Recent Weight Loss	❑	❑
Artificial Joint	❑	❑	Hay Fever	❑	❑	Renal Dialysis	❑	❑
Asthma	❑	❑	Heart Attack / Failure	❑	❑	Rheumatic Fever	❑	❑
Blood Disease	❑	❑	Heart Murmur	❑	❑	Rheumatism	❑	❑
Blood Transfusion	❑	❑	Heart Pacemaker	❑	❑	Scarlet Fever	❑	❑
Breathing Problem	❑	❑	Heart Trouble / Disease	❑	❑	Shingles	❑	❑
Bruise Easily	❑	❑	Hemophilia	❑	❑	Sinus Trouble	❑	❑
Cancer	❑	❑	Hepatitis A	❑	❑	Spina Bifida	❑	❑
Chemotherapy	❑	❑	Hepatitis B or C	❑	❑	Stomach / Intestinal Disease	❑	❑
Chest Pains	❑	❑	Herpes / Fever Blisters	❑	❑	Stroke	❑	❑
Cold Sores/Fever Blisters	❑	❑	High Blood Pressure	❑	❑	Swelling of Limbs	❑	❑
Congenital Heart Disorder	❑	❑	Hives or Rash	❑	❑	Thyroid Disease	❑	❑
Convulsions	❑	❑	Hypoglycemia	❑	❑	Tonsillitis	❑	❑
Cortisone Medicine	❑	❑	Irregular Heartbeat	❑	❑	Tuberculosis	❑	❑
Diabetes	❑	❑	Kidney Problems	❑	❑	Tumors or Growths	❑	❑
Drug Addiction/Alcoholism	❑	❑	Leukemia	❑	❑	Ulcers	❑	❑
Easily Winded	❑	❑	Liver Disease	❑	❑	Venereal Disease	❑	❑
Emphysema	❑	❑	Low Blood Pressure	❑	❑	Yellow Jaundice	❑	❑
Epilepsy or Seizures	❑	❑	Lung Disease	❑	❑		❑	❑

Have you ever had any serious illness not listed above*? (circle one) Yes No* If yes, please explain:

Note: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above statement. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient/legal guardian Date