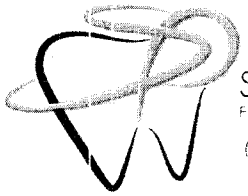
Medical Health History & Patient Information



Scheier & Price
FAMILY DENTISTRY
(610) 449-4646

Name_____Birthday_____

Cell #_____Home #_____ Married ____Single ___Other___

Address:_____City_____Zip_____

Email_____Social Security #_____

ALLERGIES: Are you allergic to any of the following? Mark with an X after condition(s)

Penicillin		Sulfa		Codeine		Seasonal	
Latex		Aspirin		Anesthetics		Other :	

If yes, please explain:

GENERAL HEALTH: Mark with an X after condition(s)

Hospitalized or Major Operation		Taking Prescribed Medications		Herbal Supplements		Antibiotic PreMedication Prior to dental treatment		Recreational Drugs	
Serious Head/ Neck Injury		Over the counter Medications		Bisphosphonate drugs for osteoporosis or cancer		Blood Thinners		Tobacco	

If yes, explain:

WOMEN, ARE YOU..... Mark with an X after condition(s)

Pregnant		Trying to Get Pregnant		Nursing		Taking Birth Control	

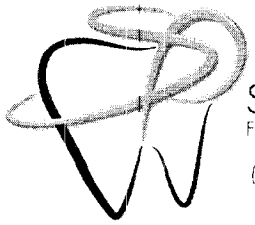
HEALTH CONDITIONS: Mark with an X after condition(s)

Chest Pain		Cancer: Type:		Alzheimers / Dementia		Sinus Issues/ Surgery	
Congenital Heart Disease		Radiation Treatments		Rheumatic Fever		STD	
Heart Attack		Chemotherapy		Glaucoma		HIV/ AIDS	
Heart Pacemaker		Tumors		Blood Disorder/ Disease		Herpes	
Mitral Valve Prolapse		Liver Disease		Arthritis		Cold Sores / Fever Blisters	
Artificial Heart Valve		Kidney Disease		Acid Reflux		PTSD	
Heart Murmur		Ulcers		Emphysema		Eating Disorder	
Cardiac/ Organ Transplant		Hepatitis: A / B / C		Blood Transfusion		Autism	
High Blood Pressure		Asthma		Diabetes : Type I or II		ADHD	
Stroke		Autoimmune disease		Stomach / Intestinal Disease		Depression	
Joint Replacement		Tuberculosis		Epilepsy / Seizures		Anxiety	
Headaches / Migraines		Bruise Easily		Hearing Impaired		Thyroid Disease Type:	
Chronic Cough		Cortisone Medication		Fainting / Dizzy Spells / Vertigo			
Other:							

DENTAL CONCERNS: Do you experience any of the following? Mark with an X after condition(s)

Pain / Sensitivity		Dry Mouth		Crooked teeth	
Clenching or Grinding		Bleeding while brushing		Stained teeth	

WHAT IS THE REASON FOR YOUR VISIT TODAY?



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DENTAL INSURANCE INFORMATION

PRIMARY
EMPLOYER_____
Subscriber: _____
Subscriber Birthdate: _____
ID/SSN _____
Company: _____

SECONDARY
EMPLOYER_____
SUBSCRIBER: _____
Subscriber Birthdate: _____
ID/SSN _____
Company: _____

Cancellation Policy: We require at least 24 hours notice to cancel an appointment or you will incur a $50 late notice fee. The fee will also apply to missed appointments. INITIAL:_____

PHOTO RELEASE: I _____the undersigned do hereby authorize and consent to the use of photographs/x-rays of me taken by [Scheier & Price Family Dentistry]. I do consent to the use of my photographs or images for marketing materials including website, social media and patient education for (Scheier & Price Family Dentistry) only.

Patient's Name: _____

Patient or Guardian Signature: _____ Date: _____

HIPAA: I have reviewed or received a copy of this office's Notice of Privacy Practices.
Print Name: _____Date: _____
SIGNATURE (Parent/Guardian signature for minor): _____

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:
Relationship to Patient _____

I give permission for Scheier Family Dentistry to discuss treatment,
Pre-authorization and account with: _____
Relationship to Patient:_____

Signature_____Date_____