TRI-VALLEY DENTAL
1144 E. MAIN STREET
HEGINS, PA 17938

Today's Date _____
Name _____
Address _____
_____
Occupation _____
Where do you Work? _____
Phone home _____ cell _____
work _____
Date of Birth _____ SS# _____
Sex M F
Single __ Married __ Divorced __ Widowed __
Emergency Contact Name _____
Phone Number _____
Relationship to Patient _____
Who referred you to our office? _____
_____

Person Responsible for Account _____
Relationship to Patient _____
Dental Insurance? Y N
Dental Insurance Company _____
Group # _____
Subscriber's Name _____
Subscriber's Birthdate _____
Subscriber's Social Security # _____
Do You Have a Second Dental Insurance Y N
Dental Insurance Company _____
Group # _____
Subscriber's Name _____
Subscriber's Social Security # _____
Subscriber's Birthdate _____

MEDICAL HISTORY

1. Physician's Name _____ Date of Last Visit _____
2. Are you under any medical treatment now? . . . . . YES NO
3. Have you had a change of health in the last 12 months? . . . . . YES NO
4. Have you been hospitalized (operation) within the past 3 years? . . . . . YES NO
5. Have you had a joint replacement or have any other medical condition requiring antibiotic pre-medication? . . . . . YES NO
6. Do you have, or have you had any of the following diseases or problems?
   A. CARDIOVASCULAR
      1. Rheumatic Fever (Rheumatic Heart Disease) . . . . . YES NO
      2. Congenital Heart Defect . . . . . YES NO
      3. Angina Pectoris (Pain in the chest that goes to jaw or arm) . . . . . YES NO
      4. Myocardial Infarction (Heart Attack) . . . . . YES NO
      5. Arrhythmias (Irregular Beat) . . . . . YES NO
      6. Heart Murmur . . . . . YES NO
      7. Heart Surgery . . . . . YES NO
      8. Congestive Heart Failure . . . . . YES NO
      9. Pacemaker . . . . . YES NO
      10. Hypertension (High Blood Pressure) . . . . . YES NO
      11. Stroke . . . . . YES NO
      12. Hypotension (Low Blood Pressure) . . . . . YES NO
      13. Can you walk a flight of stairs without trouble? . . . . . YES NO
   B. RESPIRATORY DISEASES
      1. Do you have any breathing problems? . . . . . YES NO
      2. Are you a smoker? . . . . . YES NO
      3. Do you use snuff or chewing tobacco? . . . . . YES NO
   C. ENDOCRINE DISORDERS
      1. Diabetes . . . . . YES NO
      2. Thyroid Problems . . . . . YES NO

(OVER)

D. BLOOD DISORDERS

1. Anemia (Pale complexion; often tired) . . . . . YES NO
2. Hemophilia (Do you bruise easily or bleed easily when cut?) . . . . . YES NO
3. Have you ever had a blood transfusion? . . . . . YES NO

E. EMOTIONAL CONDITIONS

Are you receiving counseling for family or stress related problems? . . . . . YES NO

F. INFECTIOUS DISEASES

1. Hepatitis . . . . . YES NO
2. Venereal Disease . . . . . YES NO
3. Tuberculosis . . . . . YES NO
4. AIDS or HIV-Positive . . . . . YES NO

G. MISCELLANEOUS DISEASES OR DISORDERS

1. Fainting (Syncope) . . . . . YES NO
2. Liver Disease . . . . . YES NO
3. Arthritis . . . . . YES NO
4. Ulcers (Stomach or Intestine) . . . . . YES NO
5. Radiation Therapy . . . . . YES NO
6. Epilepsy (Seizures) . . . . . YES NO
7. Cancer . . . . . YES NO
8. Kidney Infection . . . . . YES NO
9. Kidney Surgery or Dialysis . . . . . YES NO

6. Are you taking any medication? . . . . . YES NO

If Yes, which ones:

			Name of Medication
1. Antibiotics	YES	NO	_____
2. Blood Thinners	YES	NO	_____
3. Steroids (Cortisone, Prednisone)	YES	NO	_____
4. High Blood Pressure Medication	YES	NO	_____
5. Pain Medication	YES	NO	_____
6. Nerve Medication	YES	NO	_____
7. Birth Control Pills	YES	NO	_____
8. Heart Medication	YES	NO	_____
9. Other	YES	NO	_____

7. Do you have an allergy or reaction to:

1. Local Anesthetics (Novocaine) . . . . . YES NO
2. Penicillin . . . . . YES NO
3. Sulfa Drugs . . . . . YES NO
4. Other Antibiotics . . . . . YES NO
5. Aspirin . . . . . YES NO
6. Barbiturates . . . . . YES NO
7. Codeine . . . . . YES NO
8. Latex . . . . . YES NO
9. Other Allergies . . . . . YES NO

8. Are you pregnant? . . . . . YES NO
9. Do you have any disease, condition or problem that you think I should know about?

NOTICE OF PRIVACY PRACTICES: Our office has a Notice of Privacy Practices which describes how we may use your protected health information for treatment, payment, & health care operations purposes. A copy of our current notice is posted in our office. Any questions may be answered by our privacy officer.

_____ _____

Signature of Patient (Parent if Minor) Date Signature of Dentist Date