Tumminia Dental Associates, PA

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PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

If this appointment is for **YOU** start here →

DATE:			
NAME:			
SPOUSE:			
ADDRESS:			
CITY	STATE	ZIP	
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.	REFERRED TO US BY:		

If this appointment is for your **CHILD** start here →

DATE:			
NAME:			
SPOUSE:			
ADDRESS:			
CITY	STATE	ZIP	
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	S.S.#	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
EMPLOYER	OCCUPATION	
BUSINESS ADDRESS		
CITY	STATE	ZIP
BUSINESS PHONE NO.		
YOUR SPOUSE		
NAME		
EMPLOYER	OCCUPATION	
BUSINESS ADDRESS		
CITY	STATE	ZIP
BUSINESS PHONE NO.		

FEES AND PAYMENTS: Payment is expected upon completion of each visit. Other arrangements can be made with our Office Manager depending upon special circumstances. An estimate of the charge for any procedure you may require will be given to you before treatment. If you have any dental insurance we will be glad to fill out the proper forms. Please remember insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible, co-insurance or any other balance not paid by your insurance company

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: ( ) Examination ( ) Emergency ( ) Consultation

DENTAL HISTORY

Please Circle

Do you have a specific dental problem? Yes No Describe _____
Do you have dental examinations on a routine basis? Yes No Last visit _____
Do you think you have active decay or gum disease? Yes No Do you brush and floss on a routine basis? Yes No
Do you have clicking, popping or discomfort in the jaw joint? Yes No Do you brux or grind? Yes No
Do you have any sores or growths in your mouth? Yes No Do you ever smoke or chew? Yes No
Name of previous Dentist (optional): _____
Date of last full mouth x-rays (18 small films or panoramic): _____

MEDICAL HISTORY

Are you under a physician's care now? Yes No Who? Why? _____
Have you ever been hospitalized or had a major operation? Yes No Discuss _____
Have you ever had a serious injury to your head or neck? Yes No Discuss _____
Are you taking any medication, pills or drugs? Yes No What? _____
Are you allergic to any medications or substances? Yes No Please check below
( ) Aspirin ( ) Penicillin ( ) Codeine ( ) Acrylic ( ) Metal ( ) Latex Rubber ( ) Epinephrine ( ) Other _____
WOMEN (Please check): ( ) Pregnant/trying to get pregnant ( ) Nursing ( ) Taking contraceptives Discuss _____

- **If yes to any of the below starred conditions, please call prior to your appointment…. Premedication may be required**

Please circle YES or NO below

Heart Trouble/Disease Yes No	Hemophilia (Bleeding) Yes No	Recent Weight Loss Yes No	AIDS Yes No
Heart Murmur Yes No	Leukemia Yes No	Frequent Diarrhea Yes No	HIV Positive Yes No
Irregular Heart Beat Yes No	Recent Blood Transfusion Yes No	Diabetes Yes No	Genital Herpes Yes No
Angina/Chest Pain Yes No	Swelling of Limbs Yes No	Excessive Thirst Yes No	Drug Addiction Yes No
Heart Attack/Failure Yes No	Lung Disease Yes No	Hypoglycemia Yes No	Cold Sores Yes No
Congenital Heart Disorder Yes No	Breathing Problem Yes No	Liver Disease Yes No	Fever Blisters Yes No
Mitral Valve Prolapse* Yes No	Shortness of Breath Yes No	Hepatitis A (Infectious) Yes No	Herpes Yes No
Scarlet Fever Yes No	Frequent Cough Yes No	Hepatitis B (serum) Yes No	Stroke Yes No
Rheumatic Fever* Yes No	Hay Fever Yes No	Yellow Jaundice Yes No	Convulsions Yes No
Artificial Heart Valve* Yes No	Sinus Trouble Yes No	Kidney Problems Yes No	Epilepsy or Seizures Yes No
Heart Pace Maker* Yes No	Asthma Yes No	Renal Dialysis Yes No	Fainting or Dizziness Yes No
Heart Surgery* Yes No	Emphysema Yes No	Thyroid Disease Yes No	Glaucoma Yes No
High Blood Pressure Yes No	Tuberculosis Yes No	Parathyroid Disease Yes No	Tumors or Growths Yes No
Low Blood Pressure Yes No	Cancer Yes No	Arthritis/Gout Yes No	Nervousness Yes No
Blood Disease Yes No	X-Ray Treatments Yes No	Rheumatism Yes No	Psychiatric Care Yes No
Bruise Easily Yes No	Radiation Yes No	Pain in Jaw/Joints Yes No	Alzheimer's Disease Yes No
Anemia Yes No	Chemotherapy Yes No	Cortisone Medicine Yes No	Allergies (Medicines) Yes No
Excessive Bleeding Yes No	Stomach/Intestinal Disease Yes No	Artificial Joint* Yes No	Allergies (Pollen/Dust) Yes No
Sickle Cell Disease Yes No	Ulcers Yes No	Venereal Disease Yes No	Hives or Rash Yes No

Have you ever had any other serious illness not checked above? Yes No Discuss _____
Do you wish to talk to the dentist privately about any problem? Yes No
To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail

X_____ Date _____

Patient Signature (Parent or Guardian)

Reviewed by Doctor _____ Date _____

DENTAL AND MEDICAL HISTORIES