

Dental Savers

483 South Oxford Valley Road

Fairless Hills, PA 19030

Ph # : 215-525-6666

Patient Personal Information					
Title	Nickname	Birth Date	Age		
Last, First		Marital Status	Sex		
Address		Home #	Work #		
		Cell #	Drive Lic		
City, State, Zip		Emergency Contact	Emergency Phone #		
Email		Student	SSN		
Health Care Guardian Name		School Name			
Health Care Guardian Phone #		Referral Type			

Person responsible/guarantor for paying bills					
Title	Nickname	Birth Date	Age		
Last, First		Marital Status	Sex		
Address		Home #	Work #		
		Cell #	Drive Lic		
City, State, Zip		SSN			
Email					

Do you have Primary Dental Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you have Secondary Dental Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Group No/Name			Group No/Name		
Insurance Name			Insurance Name		
Phone #			Phone #		
Employer Name			Employer Name		
Subscriber Last, First			Subscriber Last, First		
Subscriber Address			Subscriber Address		
City, State, Zip			City, State, Zip		
Relationship to Patient	Birth Date		Relationship to Patient	Birth Date	
Subscriber ID			Subscriber ID		

Patient Medical Information					
Allergic To	<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Frequently Dry Mouth / Sjogren	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Heart Disease		
<input type="checkbox"/> Y <input type="checkbox"/> N Aspirin	<input type="checkbox"/> Y <input type="checkbox"/> N Anorexia/Bulimia	<input type="checkbox"/> Y <input type="checkbox"/> N Gag Reflex	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatoid Arthritis		
<input type="checkbox"/> Y <input type="checkbox"/> N Barbiturates / Sleeping Pills	<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N Gall Bladder Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N Seizures		
<input type="checkbox"/> Y <input type="checkbox"/> N Codeine	<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Sexually Transmitted Disease		
<input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin	<input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack/Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N Shortness of Breath		
<input type="checkbox"/> Y <input type="checkbox"/> N Iodine	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Clotting Problems	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur/Mitral Valve Prol	<input type="checkbox"/> Y <input type="checkbox"/> N Sinus Trouble		
<input type="checkbox"/> Y <input type="checkbox"/> N Latex Rubber	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Thinners	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Valve Replacement	<input type="checkbox"/> Y <input type="checkbox"/> N Stomach Ulcers		
<input type="checkbox"/> Y <input type="checkbox"/> N Local Anesthetics	<input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Tumor or Growth	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems		
<input type="checkbox"/> Y <input type="checkbox"/> N Metals	<input type="checkbox"/> Y <input type="checkbox"/> N Cardiac Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N High/Low Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis		
<input type="checkbox"/> Y <input type="checkbox"/> N Epinephrine	<input type="checkbox"/> Y <input type="checkbox"/> N Cardiovascular Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Hives	Other		
<input type="checkbox"/> Y <input type="checkbox"/> N Penicillin	<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy/Radiation	<input type="checkbox"/> Y <input type="checkbox"/> N Joint Replacement	<input type="checkbox"/> Y <input type="checkbox"/> N See Medical Questionnaire		
<input type="checkbox"/> Y <input type="checkbox"/> N NSAIDS	<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect/Heart	<input type="checkbox"/> Y <input type="checkbox"/> N Leukemia	<input type="checkbox"/> Y <input type="checkbox"/> N See Scanned Documents		
<input type="checkbox"/> Y <input type="checkbox"/> N Sulfa Drugs	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease			
<input type="checkbox"/> Y <input type="checkbox"/> N Other	<input type="checkbox"/> Y <input type="checkbox"/> N Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N Lupus			
Check, if applicable	<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N Mental Health Problems			
<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells	<input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker			
<input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Infection					

Y N Alcohol/Drug Abuse

Y N Fever Blisters/Herpes

Y N Pregnant

Y N Frequent Headaches

Y N Premedicate

Dental Questionnaire

Dental Questionnaire (Please Check Box if "Yes")

Name of previous Dentist _____

Phone _____

Date of your last cleaning _____

Last exam date _____

Date of your last full series x-rays _____

Date of last cavity detection (bitewing) x-rays _____

Do your gums bleed while brushing or flossing ?

Are your teeth sensitive to hot, cold or sweets ?

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ?

Have you ever had burning of the tongue or cracking of the corners of your mouth ?

Do you chew/smoke tobacco in any form ?

Have you had any head, neck or jaw injuries ?

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ?

Do you clench or grind your teeth ?

Have you ever had orthodontic treatment ?

If Yes, date of placement _____

Do you wear dentures or partials ?

If Yes, date of placement of dentures ? _____

Are you happy with your dentures ?

Are you having any specific problems with your teeth, gums, or mouth at this time ?

Are you happy with your smile ?

Do you have problems with teeth/fillings breaking ?

Do you regularly use dental floss ?

Do you have, or have you ever been told, that you have Pyorrhea (Periodontal Disease) ?

Do you have difficulty in opening your mouth widely ?

Do you have an unpleasant taste or odor in your teeth/mouth ?

Does food catch between your teeth ?

Do you want to learn to control your dental disease and retain your teeth ?

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list

Medical Questionnaire

Emergency Contact

Emergency contact name

Emergency contact phone

Emergency contact relationship to patient

Medical Questionnaire (Please Check Box if "Yes")

Family Physician

Phone

Are you currently under care of a Physician ?

If Yes, what is the condition being treated ?

Have you had any serious illness, operation or been hospitalized within the past 5 years ?

If Yes, what illness or problem ?

Are you currently taking any medication ?

If Yes, what ?

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast)

Have you ever taken the diet control drug Fen-Phen ?

Do you use alcoholic beverages ?

Do you smoke ?

Women Only (Please Check Box if "Yes")

Are you pregnant?

If Yes, what is your due date ?

Are you currently nursing ?

Are you on hormone replacement therapy ?

Are you on birth control pills / fertility drugs ?

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list

Pediatric Medical History (Please check box for "YES" if applicable)

Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions

Problems with physical growth or development

Sinusitis, chronic adenoid/tonsil infections

Sleep apnea/snoring, mouth breathing, or excessive gagging

Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease	<input type="checkbox"/>
Irregular heart beat or high blood pressure	<input type="checkbox"/>
Asthma, reactive airway disease, wheezing, or breathing problems	<input type="checkbox"/>
Cystic fibrosis	<input type="checkbox"/>
Frequent exposure to tobacco smoke	<input type="checkbox"/>
Jaundice, hepatitis, or liver problems	<input type="checkbox"/>
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems	<input type="checkbox"/>
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions	<input type="checkbox"/>
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder	<input type="checkbox"/>
Bladder or kidney problems	<input type="checkbox"/>
Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems	<input type="checkbox"/>
Rash/hives, eczema or skin problems	<input type="checkbox"/>
Impaired vision, hearing, or speech	<input type="checkbox"/>
Developmental disorders, learning problems/delays, or intellectual disability	<input type="checkbox"/>
Cerebral Palsy, brain injury, epilepsy, or convulsions/seizures	<input type="checkbox"/>
Autism/autism spectrum disorder	<input type="checkbox"/>
Recurrent or frequent headaches/migraines, fainting, or dizziness	<input type="checkbox"/>
Attention deficit/hyperactivity disorder (ADD/ADHD)	<input type="checkbox"/>
Behavioral, emotional, communication, or psychiatric problems/treatment	<input type="checkbox"/>
Diabetes, hyperglycemia, or hypoglycemia	<input type="checkbox"/>
Thyroid or pituitary problems	<input type="checkbox"/>
Anemia, sickle cell disease/trait, or blood disorder	<input type="checkbox"/>
Hemophilia, bruising easily, or excessive bleeding	<input type="checkbox"/>
Transfusions or receiving blood products	<input type="checkbox"/>
Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant	<input type="checkbox"/>
Mononucleosis, Tuberculosis (TB), Scarlet Fever, or Cytomegalovirus (CMV)	<input type="checkbox"/>
Methicillin resistant staphylococcus aureus (MRSA) or human immunodeficiency virus (HIV)/AIDS	<input type="checkbox"/>
Please provide details for questions answered "YES"	_____
Additional Comments	
Any other significant medical history pertaining to this child or his/her family?	_____

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature

Date