**Transcend Dental**
70 Buckwalter Rd
Suite 309
Royersford, PA 19468
Ph # : 484-369-8625
Fax # : 484-369-8635

TRANSCEND DENTAL

## Patient Personal Information

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Title | | Nickname | | Birth Date | | Age | |
| Last, First | | | | Marital Status | | Sex | |
| Address | | | | Home # | | Work # | |
| | | | | Cell # | | Drive Lic | |
| City, State, Zip | | | | Student | | SSN | |
| Email | | | | School Name | | | |
| | | | | 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? __ Yes __ No | | Do you have Secondary Dental Insurance? __ Yes __ 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**

- ☐ No Known Allergies
- ☐ Aspirin
- ☐ Barbiturates / Sleeping Pills
- ☐ Codeine
- ☐ Erythromycin
- ☐ Iodine
- ☐ Latex Rubber
- ☐ Local Anesthetics
- ☐ Metals
- ☐ No Epinephrine
- ☐ Penicillin
- ☐ Prior Hepatitis
- ☐ Sulfa Drugs
- ☐ Other Narcotics

**Check, if applicable**

- ☐ No Change Since Last Recorded
- ☐ No Known Concerns or Issues
- ☐ AIDS/HIV Infection
- ☐ Alcohol/Drug Abuse
- ☐ Anemia / Leukemia
- ☐ Ankles Swell
- ☐ Anorexia / Bulimia
- ☐ Arthritis
- ☐ Asthma / Hay Fever
- ☐ Blood Clotting Problems
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Cancer / Tumor or Growth
- ☐ Cardiac Pacemaker
- ☐ Chest Pain Upon Exertion
- ☐ Color Blindness
- ☐ Contact Lenses
- ☐ Damaged Heart Valve
- ☐ Diabetes
- ☐ Emphysema
- ☐ Environmental Allergies
- ☐ Epilepsy
- ☐ Fainting Spells / Seizures
- ☐ Fever Blisters / Herpes
- ☐ Frequent Headaches
- ☐ Frequently Dry Mouth / Sjogren
- ☐ Gag Reflex
- ☐ Gall Bladder Trouble
- ☐ Heart Attack / Stroke
- ☐ Heart Disease / Angina
- ☐ Heart Murmur
- ☐ Hepatitis / Jaundice
- ☐ High Blood Pressure
- ☐ Hives / Skin Rash
- ☐ Joint Replacement
- ☐ Kidney / Bladder Trouble
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Health Problems
- ☐ Mitral Valve Prolapse
- ☐ Persistent Diarrhea
- ☐ Premedicate
- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease
- ☐ Sexually Transmitted Disease
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Stomach Ulcers
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Unusual Weight Loss
- ☐ Urinate Frequently

**Other**

- ☐ See Dental Questionnaire
- ☐ See Medical Questionnaire
- ☐ See Scanned Documents: Pt Note

# Dental Questionnaire

## Dental Questionnaire

| | |
|---|---|
| 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 | |

## Check Box if answer is Yes

| | |
|---|---|
| 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 ever been told you have Pyorrhea ? | ☐ |
| 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 | |

## Medical Questionnaire

### Medical Questionnaire

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 ? _____

Do you have any artificial joints? _____

Are you currently taking any medication ? _____

If Yes, what ? _____

_____

Do you require antibiotic pre-medication prior to dental treatment? _____

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

Are you pregnant? _____

If Yes, what is your due date ? _____

Are you currently nursing ? _____

Do you have menstrual period problems ? _____

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 _____

### Senior Citizens

Are you in a wheelchair? _____

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

_____ _____

**Patient/Guardian Signature** **Date**