BABINER DENTAL
332 BUSTLETON PIKE
REAR SUITE
FEASTERVILLE PA 19053
215-698-2710

Section 1: Personal Information

[Mr.] [Mrs.] [Ms.] [Dr.] **First Name:** | **Last Name:**

Sex: ☐ Male ☐ Female | **E-mail:** | **Cell Phone:**

Birthdate: | **Social Security:** | **Occupation:**

Emergency Contact [Name & Number]**:**

Address (Street, City, State, Zip)**:**

How did you find out about our office?

Section 2: Dental Insurance Details

Do you have dental insurance? ☐ Yes ☐ No (If no skip section 2)

Dental Insurance Information

Are you the policy holder? ☐ Yes ☐ No | **Policyholder Name:** | **Policy Holder SS#:**

Policy Holder Birthdate: | **Policyholder place of employment:**

Dental insurance company: | **Group name:** | **Group #:**

Dental History

What is the main reason for today's visit?

Which of these apply to you?

☐ Missing teeth	☐ Bad breath	☐ Jaw popping	☐ Broken teeth
☐ Teeth grinding	☐ Gum disease	☐ Unhappy with smile	☐ Sensitive teeth
☐ Stained teeth	☐ Loose teeth	☐ Bleeding gums	☐ Food catches between teeth

How often do you floss? ☐ Daily ☐ Sometimes ☐ Never

Is there anything you would like to change about your smile?

Last dental visit?

Medical History

Please list all medications you are taking:

Please list any health conditions:

Hospitalizations or Surgery:

Allergies: **Penicillin** ☐ Yes ☐ No **Latex** ☐ Yes ☐ No **Acrylic** ☐ Yes ☐ No **Other?**

Have you ever taken any bisphosphonates (Fosamax, Actonel, Boniva?) ☐ Yes ☐ No

Women: **Pregnant?** ☐ Yes ☐ No **Nursing?** ☐ Yes ☐ No **Taking Birth Control?** ☐ Yes ☐ No

Are you taking blood thinners (Plavix, Coumadin, Aspirin, Pradaxa)? ☐ Yes ☐ No

Which of these apply to you?

Diabetes ☐ Yes ☐ No	**Asthma** ☐ Yes ☐ No	**Arthritis** ☐ Yes ☐ No
Epilepsy ☐ Yes ☐ No	**Liver disease** ☐ Yes ☐ No	**Hepatitis [A, B, C, D]** ☐ Yes ☐ No
Kidney disease ☐ Yes ☐ No	**Joint replacement** ☐ Yes ☐ No	**Mitral valve prolapse** ☐ Yes ☐ No
Rheumatic fever ☐ Yes ☐ No	**Heart murmur** ☐ Yes ☐ No	**Thyroid condition** ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No	**Ulcers** ☐ Yes ☐ No	**HIV** ☐ Yes ☐ No
Blood disorder ☐ Yes ☐ No	**Dialysis** ☐ Yes ☐ No	**High blood pressure** ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No	**Lupus** ☐ Yes ☐ No	**Organ transplant** ☐ Yes ☐ No
Heart attack ☐ Yes ☐ No	**Heart Condition** ☐ Yes ☐ No	**Recovering Opioid addiction** ☐ Yes ☐ No
Snoring / Sleep Apnea ☐ Yes ☐ No	**Emphysema** ☐ Yes ☐ No	**Eye Disorder / Glaucoma** ☐ Yes ☐ No
Abnormal bleeding ☐ Yes ☐ No	**Cancer** ☐ Yes ☐ No	**Immune disorder** ☐ Yes ☐ No
Osteoporosis ☐ Yes ☐ No	**Stroke** ☐ Yes ☐ No	**Bruise easily** ☐ Yes ☐ No

I read and understand the questions above. I agree and give my consent to any examination, anesthetic, operation or treatment that the dentist may deem necessary.

I have been informed that this practice will make reasonable effort to protect the privacy of my health information in accordance with HIPAA. I allow the doctors and staff to release any and all medical and dental information to insurance companies and other treating healthcare providers.

Our office provides a guarantee on some dental procedures as long as you come for all routine preventive services (cleanings, fluoride). Not coming regularly for these visits voids this guarantee since we can't catch problems early and prevent larger problems.

Patient signature _____ Date: _____