Marshall Dental Associates
610 W. Marshall Street
Norristown, PA 19401
Ph # : 484-704-7675

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? 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

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

Check, if applicable

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

Other

- ☐ Y ☐ N See Scanned Documents: Pt Note

☐ Y ☐ N AIDS/HIV Infection

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	
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

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	
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	
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	

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

Patient/Guardian Signature **Date**