Dental Surgeons and Associates

419 N. Chestnut Street
Scottdale, PA 15683

Dental and Medical History Information

Date: / /

Patient Information			
Last name:	First Name	Middle Name	
Home Phone:	Cell Phone:	Work Phone:	
Email Address:		SSN:	
Mailing Address	City	State	Zip Code
Date of Birth: / /	Gender:		
Occupation:			
Emergency Contact:		Relationship:	Phone:

If you are completeing this form for another person, what is your name and relationship to that person? Name_____________________ Relationship _______________________. If executing this form as the patients' personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedures on this patient. If for any reason I no longer have such legal right and authority, i will immediately notify the practice in writing.

Dental History and Symptoms			
What is the reason for your visit today?			
Are you experiencing any dental pain or discomfort? Yes or No (Please circle) If yes, where?			
Please mark an "X" in the box ONLY if this applies to you			
Is it hard to open your mouth?	☐	Have you ever had a serious injury to your head or mouth?	☐
Does it hurt to chew, bite or swallow?	☐	If yes, please describe what happened?	
Have you ever had periodontal (gum) treatments like scaling and root planning	☐		
Do you have, or have you had, any sores or growths in your mouth?	☐	Have you ever had problems with dental treatments in the past?	☐
Do you have earaches or neck pains?	☐	If yes, please describe what happened?	
Does dental treatment make you nervous?	☐		
Have you ever had a reaction to, or problem with, dental anesthesia?	☐	Are you unhappy with your smile?	☐
If yes, please describe what happened?		If yes, please describe (Color/Shape/Position of your teeth)	
Have you ever had dentures/partials? If yes please, list date		Upper: ________________	Lower:________________

Medications and Other Products/Substances	
	Please Circle Yes or No
Are you taking any **blood thinners** *(Such as coumadin, warfarin, rivaroxaban, dabigatran, clopidogrel,eliquis, heparin or asprin)?*	Yes or No
If yes, what medications are you taking?	
Are you taking any medications to treat **osteoporosis** or Paget's disease? *(Such as Fosamax, Actonel, Boniva, Reclast or Prolia)*	Yes or No
If yes, what medications are you taking?	
Are you taking or scheduled to take an **IV medication** to treat bone pain, hypercalcemia or skeletal complications results from Paget's disease, multiple myeloma or metastatic cancer? *(Such as Xgeva, Aredia, Zometa)*	Yes or No
If yes, what medications are you taking?	
Are you taking **Hormonal replacements**?	Yes or No

Do you use any form of **tobacco or nictotine products**? *(Such as cigarettes, cigars, snufff, chew, bidis)*	Yes or No
Do you use **vaping products**?	Yes or No
How many **alcoholic beverages** do you have per week? _______________	
Do you use **controlled substances** (drugs), including **marijuana**, for either medicinal or recreational reasons?	Yes or No
If yes, what is the substance and how often do you use it?	
If yes, was the substance prescribed by a doctor?	
Do you take any **other prescriptions and/or over the counter medications, vitamins, herbs and or other supplements?**	Yes or No
If yes, please list them here ?	
Women Only:	
Are you taking birth control pills?	Yes or No
Pregnant? If yes number of weeks _______________	
Nursing? If yes, number of weeks ____________	

Medications (Please List(		
Name	Dosage	Frequency

Allergies

Are you allergic to or have you had an allergic reations to:

Please circle Yes or No

Aspirin	Yes or No	Sulfa Drugs	Yes or No
Barbiturates,sedatives or sleeping pills	Yes or No	Mycins (Clindomycin,Erythromycin, azithromycin-Zpac)	Yes or No
Codeine or other narcotics	Yes or No	Pencillin (Amoxicillin)	Yes or No
Hay fever/Seasonal Allergies	Yes or No	Other	Yes or No
Iodine	Yes or No	Please describe any "Yes" answers and include information about your reaction	
Latex (Rubber)	Yes or No		
Local Anesthetics	Yes or No		
Metals	Yes or No		

Medical and Surgical History		
What is your normal blood pressure: ________________________________	Doctor's Name:	
	Doctor's Phone:	

Medical Surgical History (Please Circle Yes or No)	
Are you in good physicial Health?	Yes or No
Are you currently being seen or treated by a physician?	Yes or No
Have you had a serious illness, operation or been hospitalized in the past 5 years?	Yes or No
Have you had any type (either total or partial) of joint replacement surgery (such as hip, knee, shoulder)	Yes or No
Have you had a heart valve replacement or heart surgery?	Yes or No
Have you had an organ or bone marrow/stem cell transplant?	Yes or No

Medical History Specific - Please Circle Yes or No

Do you have or have you been diagnosised with any of the following conditions?

Heart (Cardiac) Health		**Brain (Neurological)/Mental Health**	
Pacemaker/ implanted defibrillator	Yes or No	Anxiety	Yes or No
Artifical (prosthetic) heart valve	Yes or No	Depression	Yes or No
Previous infective endocarditis	Yes or No	Epilepsy	Yes or No
Congenital Heart Disease (CHD)	Yes or No	Mental Health Disorders	Yes or No
Uprepaired, cyanotic CHD	Yes or No	Neurological Disorders	Yes or No
Repaired (Completely) in last 6 months	Yes or No	Post-Traumatic stress disorder	Yes or No
Reparied CHS with residual defects	Yes or No	Traumatic Brain Injury	Yes or No
Arteriosclerosis	Yes or No	**Autoimmune Disease**	
Coronary artery Disease	Yes or No	AIDS or HIV infection	Yes or No
Congestive Heart Failure	Yes or No	Lupus	Yes or No
Damaged Heart Valves	Yes or No	**Digestive Health**	
Heart Attack	Yes or No	Gastrointestinal Disease	Yes or No
Heart murmur/rhythm disorder	Yes or No	GE Reflux/Persistent Hearthburn	Yes or No
Rheumatic heart disease	Yes or No	Stomach Ulcers	Yes or No
Stroke	Yes or No	**Eye (Vision) Health**	
Breathing (Respiratory) Health		Glaucoma	Yes or No
Asthma (COPD)	Yes or No	**Other**	
Bronchitis	Yes or No	Arthritis	Yes or No
Emphysema	Yes or No	Chronic Pain	Yes or No
Sinus Trouble	Yes or No	Diabetes (Type I or II)	Yes or No
Tuberculosis	Yes or No	Eating Disorder	Yes or No
Cancer		Frequent Infections	Yes or No
Type:		*Type of Infection:*	
Date of Diagnosis:		Hepatitis, Jaundice or Liver Disease	Yes or No
Chemotherapy		Immune Deficiency	Yes or No
Radiation Therapy		Kidney Problems	Yes or No
Blood (Circulatory) Health		Malnutrition	Yes or No
Anemia	Yes or No	Osteoporosis	Yes or No

Blood Transfusion	Yes or No	Sexually Transmitted Disease	Yes or No
If yes, date:		Thyroid Problems	Yes or No
Hemophilia	Yes or No		
High or low blood pressure	Yes or No		

Practice Policy Reminders	
Accurate Information	You must provide us with an insurance card and/or all information to verify your coverage prior to your time of service. If information is not received prior to scheduled appointment we reserve the right to cancel appointment.
Claim Submission	DSA will submit claims for all medically necessary services to your insurance company. Please note that payment is ultimately due from you if your insurance company denies payment for any services(s); i.e. termination of coverage , coordination of benefits, non-payment of premium, non participating status, etc.
Payment	Payment is due at the time of service. If you are unable to make payment at the time of service financing options are available and must be in place prior to treatment.
Estimates	Not all dental insurance companies publish their (allowable) fee schedule; therefore, coinsurance percentages cannot always be accurately calculated for prepayment. DSA staff provide patients with a good faith estimate for patient responsibility. A DSA statement will be sent to you after your dental insurance has processed your claim for finalization of payment.
Minors	In the case of divorced or separated parents, it is YOUR responsibility to have financial arrangements made according to the divorce decree prior to treatment.
Financial Obligation	Failure to honor your financial obligation with DSA in accordance with your signed financial agreement will result in your account being **sent to collections and termination of treatment relationship,** in accordance with the regulations that govern ethical dental care.
Missed/Broken Appointments	After 3 missed appointments, DSA reserves the right to **terminate your treatment relationship**. All appointments must be canceled 48 hours prior to appointment time.

Patient Signature: ____ **Date:** ____________________________

Guardian or POA's Signature: ________________________________ **Date:** ____________________________

If signed by POA, Relationship to Patient:__________________________