DENTAL ARTS OF WYOMISSING
MICHAEL B. BALTHASER, DMD, LLC
KNOWLEDGE·SKILL·TRUST

DENTAL ARTS OF BERNVILLE
MICHAEL B. BALTHASER, DMD, LLC
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We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are immeasurable, and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you. Thank you!

ABOUT YOU

Today's date: _____

Name: _____ ❑ Female ❑ Male
Address: _____
City: _____ SS#: _____
State:_____ Zip: _____
Home phone: _____ Bus. phone: _____ Cell phone: _____
Birthdate: ____/____/_____ Employer:_____
Marital status: ❑ Single ❑ Married ❑ Widowed
E-mail address: _____ Name of spouse: _____

Who may we thank for referring you? _____

If College Student: Name of College: _____City_____State_____

EMERGENCY INFORMATION

Person to contact: _____ Phone: _____

DENTAL INSURANCE INFORMATION

Primary Insurance company: _____ Group#: _____
Subscriber Name: _____ Birth date_____
ID#:_____ SS#_____ Employer:_____
Secondary Insurance company: _____ Group#: _____
Subscriber Name: _____ Birth date_____
ID#:_____ SS#_____ Employer:_____

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. I authorize the release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I also authorize payment of dental benefits, otherwise payable to me, to be paid directly to Michael B. Balthaser, D.M.D., LLC.
Initials: _____

DENTAL HISTORY

Why have you come to the dentist today? _____
Are you currently in pain? ❑ Yes ❑ No
Do you require antibiotics prior to dental treatment? ❑ Yes ❑ No
Have you ever had a difficult problem associated with dental work? ❑ Yes ❑ No
Have you ever been treated for periodontal (gum) disease? ❑ Yes ❑ No
Do you smoke or use smokeless tobacco? ❑ Yes ❑ No
Do you brush daily? ❑ Yes ❑ No
Do you floss daily? ❑ Yes ❑ No
Have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No
Are your teeth sensitive to hot/cold/anything else? ❑ Yes ❑ No
Are you happy with your smile? ❑ Yes ❑ No
What would you like to change? _____

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MEDICAL HISTORY

Name of personal physician: _____ Approximate date of last visit: _____

Phone number: _____

Have you had any serious health problems in the last five years? ❑ yes ❑ no If yes, please explain:

_____

(For women) Are your currently pregnant? ❑ yes ❑ no If yes, how many months?

Please list prescription medications: _____

_____

Please list vitamin/herbal supplements: _____

Have you EVER taken any medications for the treatment of osteoporosis (Fosamax, Boniva, Aredia, etc)? ❑ Yes ❑ No

Please check if you're allergic to any of the following:

- ❑ Local anesthetics
- ❑ Penicillin/other antibiotics
- ❑ Barbiturates, sedatives, sleeping pills
- ❑ Sulfa drugs
- ❑ Aspirin
- ❑ Shellfish, iodine or red wine
- ❑ Codeine/other narcotics
- ❑ Latex sensitivity
- ❑ Other_____

Please List any known allergies:

Do you have, or have you had, any of the following?

- ❑ AIDS/HIV Positive
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Arthritis/Gout
- ❑ Artificial Heart Valve
- ❑ Artificial Joint
- ❑ Asthma
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problem
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chest Pains
- ❑ Chronic pain
- ❑ Cold Sores/Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ Convulsions
- ❑ Cortisone Medicine
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Emphysema
- ❑ Epilepsy or Seizures
- ❑ Excessive Bleeding
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Cough
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack/Failure
- ❑ Heart Murmur
- ❑ Heart Pace Maker
- ❑ Heart Trouble/Disease
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Mitral Valve Prolapse
- ❑ Pain in Jaw Joints
- ❑ Parathyroid Disease
- ❑ Psychiatric Care
- ❑ Radiation Treatments
- ❑ Recent Weight Loss
- ❑ Renal Dialysis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Spina Bifida
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Ulcers

Have you ever had any serious illness not listed above? If yes, please explain:_____

The information I have given is true and accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical status. I authorize this office to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature of patient/Guardian/POA: _____ Date: _____

Reviewed by: _____ Date: _____

Dentist Signature: _____ Date: _____