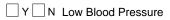
JOY Dental

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



Patient Personal Informat	ion					
Title	Nickname	Birth Date	Age			
Last, First		Marital Status	Sex			
Address		Home #	Work #			
		Cell #	Drive Lic			
City, State, Zip		Emergency Contact	Emergency			
Email		Student	Phone #			
Health Care Guardian Nam	le		SSN			
Health Care Guardian Phone #		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 Den	tal Insurance?YesN	O Do you have Secondary I	Dental Insurance?YesNo			
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	on					
Allergic To	Y N AIDS/HIV Infection	Y N Environmental All	lergies Y N Mental Health Problems			
Y N No Known Allergie	es Y N Alcohol/Drug Abuse	Y N Epilepsy	Y N Mitral Valve Prolapse			
Y N Aspirin	🗌 Y 🗌 N 🛛 Anemia / Leukemia	Y N Fainting Spells / S				
Y N Barbiturates / Slee	eping Y N Ankles Swell	Y N Fever Blisters / H	erpes Y N Premedicate			
Pills	🗌 Y 🗌 N 🛛 Anorexia / Bulimia	Y N Frequent Headac	hes Y N Rheumatic Fever			
Y N Codeine	Y N Arthritis	Y N Frequently Dry M				
	Y N Asthma / Hay Fever	Sjogren	Disease			
Y N Latex Rubber	Y N Blood Clotting Problems	Y N Gall Bladder Trou				
Y N Local Anesthetics	Y N Blood Transfusion	Y N Heart Attack / Str				
Y N Metals	Y N Bronchitis	Y N Heart Disease / A				
Y N No Epinephrine	Y N Cancer / Tumor or Growth	Y N Heart Murmur				
	Growin Y N Cardiac Pacemaker	Y N Hepatitis / Jaundi				
Y N Prior Hepatitis	\square Y \square N Chest Pain Upon	Y N High Blood Press				
Y N Sulfa Drugs	Exertion	Y N Hives / Skin Rash				
Y N Other Narcotics	Y N Color Blindness	\square Y \square N Joint Replacement				
Check, if applicable	Y N Contact Lenses	Y N Kidney / Bladder	Documente: Dt Note			
oneon, il applicable	Y N Damaged Heart Valve	Y N Liver Disease				

□ Y □ N	No Change Since Last Recorded
□ Y □ N	No Known Concerns or Issues



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.

Dentist Signature

Date