LEHIGH VALLEY CENTER FOR DENTAL HEALTH
ROBERT E. SANFORD, D.M.D.
1120 S. CEDAR CREST BOULEVARD
ALLENTOWN, PA 18103

DATE_____

EMAIL_____

NAME_____ DATE of BIRTH_____

LAST FIRST MIDDLE

GUARDIAN'S NAME, IF PATIENT IS A MINOR_____

HOME ADDRESS_____
Street *City* *State* *Zip*

HOME PHONE_____CELL PHONE_____ Work Phone _____

EMPLOYER_____ SOCIAL SECURITY NUMBER_____

CONTACT IN CASE OF EMERGENCY:

NAME_____RELATIONSHIP_____PHONE_____

Sex: Male Female Married Single Divorced Separated Widowed

Whom may we thank for referring you to our practice?

Patient_____ Friend_____
Dentist's Office_____ Doctor's Office_____
Other ? _____

DENTAL INSURANCE INFORMATION

NAME OF INSURED_____

INSURED BIRTH DATE_____ INSURED'S DRIVERS LICENSE_____

INSURED'S ADDRESS_____

INSURED'S EMPLOYER NAME_____

EMPLOYER'S ADDRESS_____

PLAN
NAME_____TELEPHONE_____

INSURANCE ID #_____ GROUP #_____

PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS CLAIMS YES NO

NAME_____ Date_____

MEDICAL INSURANCE INFORMATION

FIRST NAME OF INSURED_____LAST NAME OF INSURED_____

INSURED'S BIRTH DATE_____

INSURANCE PLAN NAME_____TELEPHONE_____

POLICY/GROUP NUMBER_____INSURANCE ID #_____

INSURED ADDRESS IF DIFFERENT THAN PATIENT'S_____

_____

RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER

MEDICAL HISTORY

Please indicate any of the following which you have ever had or do have at the present time, by circling **Y** for yes and **N** for no. These facts have a direct bearing on your dental health.

Cardiovascular System

Pain, Pressure in Chest Y N

Heart Attack Y N

Prosthetic Heart Valve Y N

Pacemaker / Defibrillator Y N

Heart Surgery Y N

High Cholesterol Y N

Heart Murmur Y N

Shortness Of Breath Y N

Swollen Ankles Y N

Stroke Y N

Blood Pressure High / Low Y N

Neurologic System

Excessive Worry Y N

Mood Disorder Y N

Irritability / Nervousness Y N

Epilepsy / Seizures Y N

Fainting / Dizziness Y N

Depression Y N

Neuralgia Y N

Parkinson's Disease Y N

Are You Under a Lot of Stress Y N

Respiratory

Persistent Cough Y N

COPD Y N

Tuberculosis Exposure Y N

Emphysema Y N

Bronchitis Y N

Asthma Y N

Digestive System

Abdominal Pain / Ulcers Y N

Hepatitis / Jaundice Y N

Liver Disease Y N

GERD / Acid Reflux Y N

IBS / Crohn's Disease Y N

Ear, Nose and Throat

Ear Ache / Hearing Loss Y N

Sinusitis Y N

Cold Sores / Fever Blisters Y N

Frequent Sore Throat Y N

Hoarseness Y N

Tonsillectomy Y N

Frequent Nose Bleeds Y N

Meniere's Disease Y N

Endocrine System

Diabetes (Type 1 or 2?) Y N

Thyroid Disease Y N

Dry Mouth Y N

Weight Change Y N

Excessive Thirst Y N

Bone, Joints, Extremities

Arthritis / Rheumatoid ? Y N

Osteoporosis Y N

Bone Infection / Gout Y N

Joint Replacement Y N

Fibromyalgia Y N

Neck Pain / Trauma Y N

Back Pain Y N

Head Trauma Y N

Swollen, Painful Joints Y N

Bone Fracture Y N

Muscle Weakness Y N

Blood System

Bleed Easily / Bruise Easily Y N

Anemia / Leukemia Y N

Problem with Immune System Y N

Genitourinary System

Kidney Problems Y N

HPV Virus Y N

Excessive Urination Y N

Other

Chronic Fatigue Y N

Chronic Pain Y N

Eye Trouble / Glaucoma Y N

Are You Pregnant / Nursing ? Y N

Numbness Y N

Numbness / Headaches Y N

Migraines Y N

Skin Disease Y N

Organ Transplant Y N

Dieting / Eating Disorders Y N

Do You Snore ? Y N

(Is it a problem for your bedmate?) Y N

Difficulty Sleeping / Sleep Apnea Y N

Neoplasms

Benign Tumor Y N

Cancer Y N

Chemotherapy Y N

Radiation Y N

Confidental Medical History

Medical Condition Y N HIV / AIDS Y N

Recreational Drugs Y N Other ?_____ Y N

SOCIAL HISTORY

Do You Use Tobacco? Y N Smoke or Smokeless?_____

If yes, how much and how often?_____

Do you drink alcohol?

If yes, how much and how often?_____

Recreational Drugs Y N

FAMILY HISTORY

Have any of your family members ever been treated for these conditions or any other medical problems: Heart Disease Diabetes High Blood Pressure Seizures Other_____

IF YOU ARE A WOMAN –

Are You Or Could You Be Pregnant? Y N

Nursing? Y N

Oral Contraceptives or Hormonal Therapy? Y N

ARE YOU ALLERGIC / SENSITIVE TO ANY MEDICATIONS OR MATERIALS?

PENICILLIN – OTHER ANTIBIOTICS Y N LATEX Y N

ASPIRIN Y N PAIN PILLS – SEDATIVES Y N

LOCAL ANESTHETIC Y N JEWELERY / METALS Y N

OTHERS? _____

Do you have any disease, condition or problem not listed that you think we should know about? Y N. If yes, please explain_____

WHEN WAS YOUR LAST VISIT WITH A MEDICAL DOCTOR? _____

PLEASE LIST THE NAME OF YOUR MEDICAL DOCTOR(S)

Primary Care Doctor_____

Specialists_____

_____

Please List All Surgeries or Hospitalizations_____

_____

PLEASE LIST BELOW ALL MEDICATIONS, NUTRITIONAL SUPPLEMENTS, DOSAGES THAT YOU PRESENTLY TAKE.

1_____ 9_____
2_____ 10_____
3_____ 11_____
4_____ 12_____
5_____ 13_____
6_____ 14_____
7_____ 15_____
8_____ 16_____

Have you ever been pre-medicated for dental treatment? If YES, why _____

Why did you choose to come see Dr. Sanford today?

_____
_____
_____
_____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING (PLEASE CIRCLE):

Face Pain Jaw Pain

Lip or Cheek Biting Cold Sores / Fever Blisters

Loose Teeth Burning Sensation on the Tongue

Broken Fillings Mouth Breathing

Sensitivity or Pain When Brushing Orthodontic Treatment

Fingernail Biting Sensitivity When Biting on Something

Do You Grind or Clench Your Teeth Sensitive Teeth to Hot, Cold, Sweets

Sore Teeth Bleeding Gums

Have You Had a Cavity in the Last 3 Yeasr? Complications after Dental Treatment

BITE SCREENING

Do You Have Any Chipped Teeth? Broken Teeth? Worn Down Teeth?

DO YOU NOW, OR HAVE YOU EVER HAD, PAIN, CLICKING OR POPPING, IN YOUR JAW JOINT (IN AND ABOUT THE EARS)? _____

DO YOU WEAR A DAY/NIGHT BITE APPLIANCE? _____

DO YOU NOW OR HAVE YOU EVER HAD **"TMJ"**? Y N

DENTURE SCREENING

DO YOU WEAR FULL OR PARTIAL REMOVABLE DENTURES? Y N
HOW LONG HAVE YOU WORN DENTURES?_____
DO YO USE DENTURE ADHESIVE? Y N

HOW MANY TIMES DURING THE DAY DO YOU APPLY IT?_____

DENTAL HISTORY

DATE OF YOUR LAST DENTAL VISIT_____

WHAT WAS DONE AT THAT VISIT?_____

WHY DID YOU LEAVE YOUR LAST DENTIST?_____

HOW OFTEN DO YOU HAVE YOUR TEETH CLEANED?_____ TIME IT TAKES?_____

DATE OF YOUR LAST FULL MOUTH SERIES OF X-RAYS_____

PLEASE CHECK ANY OF THESE ITEMS YOU NOW USE TO CARE FOR YOUR MOUTH

BRUSH____HOW OFTEN_____ POWER TOOTHBRUSH_____

FLOSS_____HOW OFTEN_____ WATER IRRIGATOR_____ OTHER_____

EVALUATE YOUR DENTAL HEALTH EXCELLENT ( ) GOOD ( ) FAIR ( ) POOR ( )

DO YOU HAVE TROUBLE GETTING NUMB? Y N

DO YOU HAVE UNREPLACED MISSING TEETH? Y N

PRIOR ORTHODONTIC TREATMENT y N

DO YOU GET FRUSTRATED BECAUSE YOU ALWAYS HAVE SOMETHING TO BE TREATED OR REPAIRED WHEN YOU VISIT A DENTIST? Y N

DO YOU WANT TO RETAIN YOUR TEETH? Y N NOT SURE

ARE YOU APPREHENSIVE ABOUT DENTAL TREATMENT? Y N

APPEARANCE RELATED DENTISTRY

DO YOU HAVE ANY DISCOLORED TEETH THAT BOTHER YOU **Y N**

WHAT DON'T YOU LIKE ABOUT YOUR SMILE?

_____

_____

WOULD YOU LIKE TO DISCUSS ENHANCING THE APPEARANCE OF YOUR SMILE? **Y N**

DO YOU WANT WHITER TEETH? **Y N**

PLEASE RANK HIGHEST TO LOWEST (1 TO 4) THE FOLLOWING THAT WOULD PREVENT YOU FROM HAVING DENTAL TREATMENT:

FEAR OF PAIN #_____ LACK OF CONCERN #_____

COST OF TREATMENT # _____ MISSING WORK TIME # _____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE AND THAT THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE DR. SANFORD'S OFFICE TO RELEASE ANY INFORMATION INCLUDING DIAGNOSIS AND THE RECORDS OF ANY TREATMENT EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYERS AND/OR HEALTH PRACTITIONERS. I FURTHER WILL ALLOW HIM PERMISSION TO DISCUSS MY CONDITIONS WITH MY PHYSICIAN AND TO REQUEST MEDICAL INFORMATION FROM HIM.

I WILL ALLOW DR. SANFORD TO PHOTOGRAPH AND USE FOR EDUCATIONAL AND/OR MARKETING PURPOSES ANY ASPECT OF MY DENTAL CONDITION OR TREATMENT PROCEDURE, INCLUDING BEFORE AND AFTER PHOTO RESULTS.

SIGNED:_____DATE:_____

RECEIVED AND WITNESSED BY_____DATE:_____