ADVANCED
DENTISTRY OF WESTTOWN
WHERE BEAUTIFUL SMILES BEGIN

1580 McDaniel Drive Westtown Business Center West Chester PA 19380
Ph.: **484-902-0100** **www.westtowndentist.com**

Title____ Last Name_____ First Name_____ MI____ Nickname_____

DOB____/____/_____ Gender_____ SSN_____ Marital Status_____

Home Address_____

Employer Name_____ Occupation_____

Home phone #_____Cell phone #_____

May we call you at work? Y/N, Work Phone #_____ Email Address_____

How you want us to confirm your reserved appointment? (circle one) Home Phone #, Cell Phone # Email

In case of an emergency, please provide name and phone number of a close relative or friend not living with you:

Name_____ ____ Relationship to patient_____Telephone #_____

Person Responsible for Fee (if other than patient):

Name_____ ___ SSN_____ DOB: ____/_____/_____

Relationship_____Address_____ Phone #_____

Date of last dental visit: _____/_____/_____ Reason for today's visit: _____

Are there any changes you would like to make to your smile? Y/N

How did you hear about our office? _____

Health History Information

Please list all medications you are currently taking (prescription and over the counter):

_____ _____ _____

_____ _____ _____

Are you currently taking Coumadin or any other blood thinners including aspirin? Y/N _____

Do you need to take antibiotic pre-medication prior to dental treatment? Y/N _____

Are you taking bisphosphorate medication? Y/N

Are you allergic to Penicillin? Y/N Are you allergic to Sulfa? Y/N Are you allergic to latex? Y/N

Please list all allergies: None or_____ _____ _____ _____

Medical History: Do you have or have you ever had any of the following:

- Heart Problems Y/N please explain_____
- Immuno-compromised condition Y/N please explain_____
- Artificial Joints Y/N type and year placed_____
- Hepatitis or Liver Disease Y/N type _____ Diabetes Y/N type_____

- Cancer Y/N type_____ Radiation treatment Y/N year_____
- Heart Valve Replacement Y/N _____ High Blood Pressure Y/N Stroke Y/N, Year _____
- Congenital Heart Defect Y/N Pacemaker Y/N Tuberculosis Y/N
- Pulmonary Shunt or Conduits Y/N Anxiety and/or Depression Y/N
- History of infective endocarditis Y/N Epilepsy Y/N Kidney Disease Y/N

Only for Females: Are you currently pregnant? Y/N

Have you been admitted to a hospital or needed emergency care during the past 2 years? Y/N

If yes, please explain_____

Have you ever had complications following dental treatment? Y/N

If yes, please explain_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at my next appointment.

X_____ _____ Date: _____

Consent for Service

As a condition of your procedures rendered by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services RENDERED are charged directly to the patient and that he or she is personally responsible for the payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collection from insurance companies and will credit any such collections to the patient account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. As a participating provider, we must have your responsibility paid on the date of the services for the dental services rendered.

X_____ _____ _____

Signature of patient, parent or guardian Date Relationship to patient

I have read and reviewed both pages of this patient information page and all of the information is correct and complete.

Initial	Date	Initial	Date	Initial	Date	Initial	Date
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Imagine how we can make you smile again and be your dental health advisor.