Patient Information

Date_____

Patients name_____

Address_____

Home Phone_____ Cell Phone_____

Email_____ Birthdate_____ SSN#_____

To Whom may we thank for referring you to our office?_____

Parent/Guardian Information

Name_____

Address_____

Home Phone_____ Cell Phone_____

Birthdate_____ SSN#_____ Relationship to patient_____

Dental Insurance Information

Policy holder's name_____ SSN#_____

DOB_____ Phone number_____

Insurance company_____ ID #_____ Group #_____

Insurance Phone number_____ Insured's employer_____

Dual Dental Insurance Information

Policy holder's name_____ SSN#_____

DOB_____ Phone number_____

Insurance company_____ ID #_____ Group #_____

Insurance Phone number_____ Insured's employer_____

Emergency Information

Person to contact in case of emergency_____

Address_____

Phone_____

BOULEVARD
DENTAL ASSOCIATES, PC

430 Kenhorst Blvd Reading, PA 19611 Phone: 610-775-032 www.BoulevardDentist.com

HEALTH HISTORY

1. Have you been a patient in the hospital in the last 2 years? Yes No
   If so, for what reason?_____
   Name and address of Physcian_____
2. Are you currently taking any medications, drugs, vitamins or supplements? Yes No
   If yes, please list_____
3. Are you allergic to any medications? Yes No
   If so, list_____
4. Do you smoke or use tobacco? Yes No Do you use recreational drugs? Yes No
5. Do you drink alcohol? Yes No How often_____
6. **Indicate which of the following you have or had**

Heart failure or attack	Yes	No	Cancer	Yes	No
High blood pressure	Yes	No	Chemotherapy/radiation	Yes	No
Heart Valve replacement/repair	Yes	No	Organ transplant	Yes	No
Heart disease/Heart defect	Yes	No	Artificial joints	Yes	No
Heart Pacemaker	Yes	No	Pain in jaw joints	Yes	No
Heart surgery	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	Lung disease	Yes	No
Kidney disease/dialysis	Yes	No	Asthma	Yes	No
Allergies	Yes	No	Acid reflux/GERD	Yes	No
Allergy to latex	Yes	No	Autoimmune disease	Yes	No
Allergy to jewelry/metal	Yes	No	Thyroid Disease	Yes	No
Liver disease	Yes	No	STD'S/Venereal disease	Yes	No
Hepatitis	Yes	No	AIDS/HIV	Yes	No
Arthritis	Yes	No	Stroke	Yes	No
Anemia	Yes	No	Alzheimer's/dementia	Yes	No
Blood transfusion	Yes	No	Neurological disorder	Yes	No
Hemophilia	Yes	No	Psychiatric treatment	Yes	No
Sickle cell disease	Yes	No	Anxiety/depression	Yes	No
Fainting/dizzy spells	Yes	No	Alcohol or drug addiction	Yes	No
Sleep apnea	Yes	No	Do you have a learning disability?	Yes	No
Are you on birth control?	Yes	No	Osteoporosis	Yes	No
Are you pregnant/nursing?	Yes	No	Cosmetic surgery	Yes	No

7. Do you have any condition or problem not listed?_____

Reviewed by_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I verify that the above information is true and correct to the best of my knowledge. I hereby authorize Boulevard Dental Associates and their staff to perform for me and or my dependents such dental treatment, medication or therapy as they deem appropriate and in connection therewith to take or prepare x-rays, models or other diagnostic aids. I acknowledge that the performance of dental services (especially the use of anesthetic) inherently involves some risk.

Patient (Guardian if minor) signature_____ Date_____