Dental Arts of Great Valley

183 Lancaster Ave
Malvern, PA 19355
Phone: (610)540-7008
www.dentalartsofgv.com

Patient Last Name	Patient First Name	M I	Preferred Name	Date (mm/dd/yy)

Social Security #	Date of Birth	Gender	Family Status
Phone (Mobile)	Phone (Home)		Phone (Work)

Email		Preferred contact			
Address				Apt #	
City		State		ZIP	

HEALTH INFORMATION

Date of Last Visit:		Reason for this Visit:	
☐ AIDS	☐ Tuberculosis	☐ Kidney Disease	☐ Dialysis
☐ Respiratory Problems	☐ Asthma	Do you carry an inhaler ☐ Yes ☐ No	
	How often do you use inhaler:		
Thyroid Condition ☐ Hypothyroidsm		☐ Hyperthyroidsm	
☐ COPD	☐ Emphysema	☐ Bronchitis	☐ Sinus Problems
☐ GI Problems	☐ GERD	☐ Ulcers	☐ Colitis
☐ Liver Disease	☐ Hepatitis	Type of Hepatitis:	
☐ Cancer	Details:		
Are you currently in treatment			☐ Yes ☐ No
History of Chemo:		History of Radiation therapy:	

☐ Nervous Disorders	History of Seizures:		
☐ Head and face injuries	Details:		
☐ Heart Disease			
☐ High Blood Pressure	☐ Pacemaker	☐ Anemia	☐ Fainting
☐ Excessive Bleeding	☐ Arthritis	☐ Rheumatic Fever	☐ Rheumatism
☐ Diabetes	☐ Glaucoma	☐ Dizziness	☐ Hay Fever

☐ Stroke:	Details:
☐ Blood Disease:	Details:
☐ Mental Disorders:	Details:

☐ Pregnancy: Due Date:	mm/dd/yy	Nursing: (Date (mm/dd/yy):
Please list all surgeries with Dates (mm/dd/yy)		
Need for premed with antibiotics ☐ Yes ☐ No Details:		
Allergies … ☐ Latex Others please specify >>		

Have you ever had any complications following dental treatment?	☐ Yes ☐ No
If yes, please explain:	

Have you been admitted to a hospital or needed care during the past two years ?	☐ Yes ☐ No
If yes, please explain:	

Name of Physician:		Phone #	
Do you have any health problems that need further clarification ?			☐ Yes ☐ No
If yes, please explain:			

Please list all medications that you are taking, prescriptions and supplements:

Name of medicine	Reason	Dosage

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 doctors at the next appointment, without fail

Signature of Patient / Parent / Guardian	Date (mm/dd/yy)