PATIENT INFORMATION:

Patient / Parent or Guardian Signature:

MARCIA A. GORDON, D.D.S. 7939 HONEYGO BOULEVARD, SUITE 214 NOTTINGHAM, MARYLAND 21236-5992 www.marylanddentalcare.com

NAMEFIRSTMILAST	Age Sex	HOME PHONE ()				
Address	APT NO	Work Phone ()				
CITY STATE		EmpLoyer				
		Occupation				
BIRTHDATE SSN -		- Cectanion				
	RELATIONSHIPPHONE ()					
Are any of your family members patients of this practice? Yes No	NAMERELATIONSHIP					
Whom may we thank for referring you to our office?						
If the person responsible for the account is different than the pa	TIENT, PLEASE FILL IN TH	IIS SECTION:				
NAME FIRST MI LAST	P	Home Phone ()				
Address	ART NO	Work Phone ()				
CITYSTATE		EMPLOYER				
BIRTHDATE SSN -		Occupation				
PRIMARY DENTAL INSURANCE (Leave blank only if no dental benefits)	NAME OF INSURED I	F DIFFERENT THAN PATIENT:				
Name	Name	RELATIONSHIP				
Address	Address	· .				
CITY STATE ZIP	Сіту	State Zip				
PHONE GROUP NO	BIRTHDATE	SS NUMBER				
Policy Number	Employer					
SECONDARY DENTAL INSURANCE	MESTER AT LEASE	F DIFFERENT THAN PATIENT:				
Name		RELATIONSHIP				
Address	· 图45000000000000000000000000000000000000					
CityStateZip		STATE ZIP				
PHONE GROUP NO.	BIRTHDATE	SS Number				
Policy Number	Employer					
DENTAL HISTORY						
What is the reason for this appointment?						
Are there any specific dental problems we should be aware of?						
Do you think you have any decay or cavities?	NO How often	DO YOU BRUSH?				
Do your gums bleed easily when brushing or flossing?	NO HOW OFTEN	DO YOU FLOSS?				
Do you suffer from chronic bad breath or bad taste?	ON C					
Do you have any jaw joint cracking or pain?						
What was the purpose of your last dental appointment?	When was that?					
When was the last time you had a dental cleaning?	NAME OF PRE	EVIOUS DENTIST?				
When were the last full mouth X-rays taken of your teeth?						
How would you describe your dental health?	ENT GOOD G	FAIR POOR				
D. WILLIAM TOTAL OF A COLUMNIA						
PATIENT TREATMENT CONSENT • I authorize the Dentist(s) or designated staff treating me to perform suc	h diagnostic aids deemed	d appropriate Programs suppress or naversary				
to make a thorough diagnosis of my dental needs. Upon such diagnosis all recommended treatment and therapeutic procedures to include admit the Dentist(s) and mutually agreed upon by me.	, I authorize the Dentist(s) to perform				
I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance						
policy(s) to the Dentist. This Form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist(s) to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier as						
necessary and / or requested. I agree to be responsible for payment of all services rendered on my beh	alf or my dependents. I a	gree that any				
unpaid claims the carrier does not pay or any balance that extends beyowill be assessed a service charge of 1½% per month.	and 60 days from the date	e of treatment				

Date:

MEDICAL HISTORY

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

Do you have or have you ever	BEEN TREATED	FOR:						
	YES			YES		i e	YES	NO
ANY HEART PROBLEMS			DO YOU SMOKE	Q	0	ALLERGIC REACTION TO (HIVES / SWELLING)	0	0
HEART ATTACK	0		LUNG/BREATHING PROBLEMS		0	PENICILLIN	0	0
ANGINA	Q		ASTHMA		0	ERYTHROMYCIN	0	0
BYPASS			BRONCHITIS			SULFA	0	0
PACEMAKER	0		EMPHYSEMA		0	CODEINE		0
STROKE			TUBERCULOSIS			ASPIRIN		
HIGH BLOOD PRESSURE			SINUS TROUBLE			LOCAL ANESTHETIC (NOVOCAIN)		
LOW BLOOD PRESSURE			DIABETES			ARE YOU AWARE OF BEING ALLERGIC TO ANY OTHER MEDICATIONS OR		
HEART MURMUR*			DIFFICULTY IN HEALING		0	SUBSTANCES? Please list below:	0	
MITRAL VALVE PROLAPSE*			LIVER PROBLEMS/DYSFUNCTION					
HEART VALVE DEFECT*			HEPATITIS/JAUNDICE	0				
HEART VALVE REPLACEMENT*			KIDNEY PROBLEMS/DYSFUNCTION					
RHEUMATIC FEVER*			STOMACH TROUBLE/ULCERS			SEXUALLY TRANSMITTED DISEASES	Q	
ARTIFICAL JOINT (HIP / KNEE)*			ALCOHOLISM			OTHER INFECTIOUS DISEASES		
ANY BLEEDING DISORDERS			DRUG ABUSE			HIV / AIDS	0	
ANEMIA			NERVOUS OR MENTAL DISORDER			CANCER / TUMOR	0	
HEMOPHILIA			EPILEPSY OR SEIZURES			OTHER GROWTHS	0	
SICKLE CELL TRAIT			THYROID PROBLEMS	0		CHEMOTHERAPY / RADIATION THERAPY	0	
BLOOD TRANSFUSIONS			ADRENAL/PITUITARY PROBLEMS		0	ARE YOU PREGNANT?		0
Are you presently taking any (ie., blood pressure, birth a list there any condition or prohistory that has not been men date: Interviewer n	CONTROL, STER	ioids,	HORMONES)	Prem Reas Med	NEDICA ON: NICAL 4	For: For: For: For: ATION RECOMMENDED: YES ALERT RECOMMENDED: YES		
MEDICAL HISTORY REVIEW AN DATE NO CHANGE CI	HANGE LIS	Γ:	Ily by doctor / hygienist)	3)		ARDIAN SIGNATURE DOCTOR / HYGIENIST SIG	iNATU	JRE
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