Joppa Partners PA, Dr, Sehdev and Rosengarden
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Towson,MD 21204 410-823-1413
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PATIENT INFORMATION Today's Date: _____

First Name: _____ MI:_____ Last Name_____ Nickname:_____

Sex: __M __F Date of Birth: _____ Age:_____ SS#_____ E-mail:_____

Address: _____ City:_____ State:_____ Zip:_____

Home Phone: _____ Bus. Phone: _____ Cell Phone: _____

Employer: _____ Ref By: _____

Dentist: _____ Medical Dr._____

Date of Last Medical Exam: _____ Driver's License #:_____

Emer Contact: _____ Relationship: _____ Phone:_____

Do you belong to PPO or HMO? Yes No

PERSONAL INFORMATION

Marital Status: __Married __Divorced __Legally Separated __Widow __Single

Employment: __NA __Full Time __Part Time __ Retired

Student: __NA __Full Time __Part Time

RESPOSIBLE PARTY (If self, skip to next section)

__Self __ Spouse __Father __Mother __Other Home Phone: _____

Name: _____ SS#:_____ Date of Birth: _____

Address: _____ City:_____ State:_____ Zip:_____

Employer: _____ Phone:_____

PRIMARY DENTAL INSURANCE COMPANY

Employer: _____ Business Address: _____

Phone: _____ Plan:_____ Insurance Company: _____

Group Name: _____ Group #_____ ID#_____

Primary Insured: _____ Relationship to Primary Insured: _____

DENTAL INFORMATION

Reason for Today's visit: __Emergency __Exam __Scheduled Procedure __Consultation

Are you in any pain: __Yes __ No If yes, how long have you been in pain? _____

Please indicate if you have any of the following problems by checking off the corresponding box:

__Discomfort, Clicking or Jaw Popping __Lost or Broken Filling __Stained Teeth __Ringing Ears

__Red, Bleeding or Swollen Gums __ Teeth Grinding __Locking Jaw __Bad Breath

__Sensitive Tooth or Gums __Blisters/Sores in or around Mouth __Broken/chipped Tooth __Other (explain)

Have you ever required Pre-Medication? __Yes __No __ Not Sure

Previous Dentist: _____ Address:_____ Phone:_____

Last Dental Exam: _____ Last Dental X-Rays:_____

How many times per day do you brush? _____ How many times per week do you floss? _____

What type of toothbrush bristles do you use? __Soft __Medium __Hard __Electric Brush

Do you use: Waterpic __Yes __ No Mouth rinse __Yes __No

Do you or family have a history of gum disease? __ Yes __No Has the fear or Apprehension of Dental work kept you from regular visits?

Did you ever have Bleaching? __Yes __No WT Extracted? __Yes __ No Root Canals? __Yes __ No

Crowns? __ Yes __ No Periodontal Treatment? __Yes ___ No

MEDICAL HISTORY

Are you taking any of the following medications? __Nerve Pills __Pain Killers __Muscle relaxer

__Stimulants __Blood Thinners __Tranquilizers __Insulin __Other (List)

Other Medications: _____

Are you in good Health? __ Yes __No

Do you have or have had any of the following diseases, medical conditions or procedures? Please check proper box.

Y N	Y N	Y N	Y N
_ _ Heart Attack? Stroke	_ _ Thyroid Problems	_ _ Cancer/Tumors	_ _ Cosmetic Surgery
_ _ Heart Surgery/Pacemaker	_ _ Kidney Problems	_ _ Shingles	_ _ X-Ray or Cobalt TX
_ _ Heart Murmur	_ _ Liver Problems	_ _ Hepatitis	_ _ Chemotherapy
_ _ Rheumatic Fever	_ _ Jaw Problems TMJ/TMD	_ _ HIV/AIDS/ARC	_ _ Ashtma
_ _ Artificial Valves	_ _ Respiratory Problems	_ _ Arthritis/Rheumatism	_ _ Difficulty Breathing
_ _ Mitral Valve Prolapse	_ _ Sinus Problems	_ _ Artificial Bones/Joints	_ _ Diabetes/Hypoglycemia
_ _ Heart Disease	_ _ Stomach Problems/Ulcers	_ _ Emphysema	_ _ Leukemia
_ _ Congenital Heart Defect	_ _ Psychiatric Problems	_ _ Fainting/Seizures/Epilepsy	_ _ Glaucoma
_ _ Chest Pains	_ _ Venereal Disease	_ _ Severe/Frequent Headache	_ _ Bleeding Problems
_ _ Scarlet Fever	_ _ Alcohol/Drug Abuse	_ _ Frequent Neck Pain	_ _ High/Low Blood Pressure
_ _ Nervousness	_ _ Tuberculosis TB	_ _ Back Problems	_ _ Anemia

Are you currently or have you taken in the past(either orally or throughIV) any of the following drugs:

Y N

_ _ Actonel(Risedronate),bondia(ibandronate) or Fosamas(Alendronate) for Osteoporosis

_ _ Donefos(Clondronate),Ostac(Clondronate) or Aredia(Pamidronate) for Cancer

_ _ Didronel (Etidronate) or Skelid (Tiludronate) for Paget's

List any other medical conditions you have or have had :_____

Are you allergic to the following? __ Latex __ Tetracycline __Aspirin __ Dental Anesthetics

__ Penicillin/Amoxicillin __Not Sure __ other(list)

Other Allergies:_____

Do you smoke? __Yes __ No How many per day?_____ How long have you smoked?_____

Other tobacco products? __ Yes __ No What type of tobacco?_____How often?_____ How Long?_____

For Women Only:

Are you currently pregnant? __Yes __ No If yes, How many months are you?_____

Are you nursing? __ Yes __ No

I agree to the HIPAA terms.

Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with our office. If the account is not paid in full of the date of services and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting you account. There is a missed appointment fee of $40.00 per hour if less than 24 hour notice given.

I authorized the staff to perform any necessary services need during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature:_____Date:_____

__Adult Patient __Parent or Guardian __Spouse