Joseph A. Mirtaj, DMD
www.pennridgedental.com

# Patient Information

Date: ____/____/_____ Social Security: _____ Birth date: _____/_____/_____

Name: _____ Cell Phone: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Status: ☐ Married ☐ Child ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Employer: _____ E-mail: _____

Business Address: _____ Business Phone: _____

_____ Occupation: _____

Whom may we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone: _____

**Dental Insurance-1st coverage**

Name of Dental Insurance Company: _____

**Dental Insurance-2nd coverage**

Name of Dental Insurance Company: _____

## Assignment and Release

I hereby authorize payment directly to Joseph A. Mirtaj, DMD for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependants. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ Date: _____

## Medications

Pharmacy: _____ Pharmacy Phone # _____

| Medications | Dosage | Reason |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

## Dental History

Former Dentist _____ Date of last X-Rays _____

City, State _____ How often do you floss? _____

Date of last Dental visit _____ How often do you Brush? _____

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# Patient Information

## Medical History

Physicians Name: _____ Phone# _____ Date of last visit:_____

| | Yes | No |
|---|---|---|
| 1. Are you currently under medical treatment? | ☐ | ☐ |
| 2. Have you ever had any serious illnesses or operations? | ☐ | ☐ |
| 3. Do you pre-medicate with antibiotics Prior to dental procedures? | ☐ | ☐ |
| 4. Do you Smoke? | ☐ | ☐ |
| 5. Do you use alcohol or other recreational drugs? | ☐ | ☐ |
| 6. Have you ever taken Phen-Phen? | ☐ | ☐ |

| 7. Have you had any allergic reactions to the: Following | Yes | No |
|---|---|---|
| Local anesthetics (e.g. Novocain) | ☐ | ☐ |
| Penicillin or other antibiotics | ☐ | ☐ |
| Sulfa drugs | ☐ | ☐ |
| Barbiturates (Sleeping Pills) | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Other | ☐ | ☐ |
| 8. (Women Only) Are you: | | |
| Pregnant? | ☐ | ☐ |
| Nursing? | ☐ | ☐ |
| Taking birth control pills? | ☐ | ☐ |

**Please check all that apply:**

| | | |
|---|---|---|
| ☐ Aids | ☐ Epilepsy | ☐ Pacemaker |
| ☐ Anemia | ☐ Fainting or Dizziness | ☐ Psychiatric Care |
| ☐ Arthritis, Rheumatism | ☐ Glaucoma | ☐ Radiation Treatment |
| ☐ Artificial Heart Valves | ☐ Headaches | ☐ Respiratory Disease |
| ☐ Artificial Joints | ☐ Heart Murmur | ☐ Rheumatic Fever |
| ☐ Asthma | ☐ Heart Problems | ☐ Scarlet Fever |
| ☐ Back Problems | ☐ Hepatitis-Type | ☐ Shortness of Breath |
| ☐ Bleeding Problems | ☐ Herpes | ☐ Seizures |
| ☐ Blood Disease | ☐ High Blood Pressure | ☐ Sinus Trouble |
| ☐ Cancer | ☐ HIV Positive/Aids | ☐ Stroke |
| ☐ Chemotherapy | ☐ Jaundice | ☐ Swelling of Feet/Ankles |
| ☐ Circulatory Problems | ☐ Jaw Pain | ☐ Swollen Neck Gland |
| ☐ Condenital Heart Disease | ☐ Kidney Disease | ☐ Thyroid Problems |
| ☐ Cortisone Treatments | ☐ Liver Disease | ☐ Tonsillitis |
| ☐ Cough – Persistent or bloody | ☐ Low Blood Pressure | ☐ Tuberculosis |
| ☐ Diabetes | ☐ Leukemia | ☐ Tumor or growth on head/neck |
| ☐ Emphysema | ☐ Mitral Valve Prolapse | ☐ Ulcer |
| | | ☐ Venereal Disease |

I understand a broken appointment charge may be applied to my account for missed appointments or appointments canceled without 24 hours notice.
I certify that I have read and understand the above statement. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction and I will not hold Pennridge Dental Associates, LLC. or any of their staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient's Name: _____

Signature of Patient/Guardian _____ Date _____

Dr. _____ Date _____