

Halifax Dentistry Patient Information

Patient's Name _____ Birth date _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____

Email Address (PRINT) _____ e-newsletter? YES/NO

Married/Divorced/Widowed/Single (circle one)

Sex: Male/Female Age _____ SS# _____ Occupation _____

Employer/School _____ Work Phone # _____

Spouse's Name _____ Birth date _____

Spouse's Employer _____

***If you have dental insurance we will make a copy of your card for our records. A social security # of the policyholder and patient is needed to process the insurance properly.**

IN CASE OF AN EMERGENCY PLEASE CONTACT _____

Relationship to patient _____ Phone # _____

I _____ understand that I am financially responsible for all charges the day of my service. I understand that Halifax dentistry will submit the appointment to my insurance company electronically and they (insurance) will reimburse me according to their allowance. I understand that I may pay by cash, check, or credit card.

Signature

Date

Who may we thank for referring you? _____

Reason for today's visit _____

Pentti J Nupponen, DMD, MAGD, CNC, FIAOMT
207 Market Street, PO Box L, Halifax, PA 17032-0466

(717) 896-3911

(800) 929-2844

fax (717) 896-2945

www.halifaxdentistry.com

Dental History

Former Dentist Name _____

Date of last dental visit _____ Last dental cleaning _____

Date of last dental x-rays full mouth or bitewings _____

Circle the condition if you have it NOW:

bad breath	bleeding gums	mouth blisters	burning tongue
chewing on one side	smoker/chew	popping jaw	dry mouth
bite fingernails	dental implants	root canals	amalgam mercury fillings
braces	retainers/dentures	jaw pain/ear	grinding teeth
broken filling	loose tooth	periodontal surgery	cold/sweet/heat/bite sensitive

How often do you brush? _____ How often do you floss? _____

Brush your tongue YES/NO Oral Irrigator YES/NO Mouthwash YES/NO

Medical History

Medical Doctor's Name _____

Specialist's Name _____

Alternative Physician's Name _____

Chiropractor's Name _____

Circle the condition if you HAVE IT NOW or if you HAVE EVER HAD it:

AIDS/HIV	Arthritis/Rheumatism	Artificial Joints	Artificial Heart Valve
Asthma	Autism Spectrum Disorder	Back Problems	Blood Disorder
Cancer (type):		Chemical Dependency	Chemotherapy
Circulation Problems		Persistent Cough	Diabetes
Emphysema	Epilepsy	Glaucoma	Headaches
Hepatitis	Herpes	High Blood Pressure	Kidney Disease
Liver Disease	Nerve problems	Low blood pressure	Psychiatric care
Fainting/dizzy	Radiation Treatment	Respiratory Disease	Rheumatic Fever
Scarlet Fever	Shortness of Breath	Sinus Trouble	Skin Rash
Special Diet	Stroke	Swollen Ankles	Swollen Neck Glands
Thyroid Problems		Tonsillitis	Tuberculosis
Tumor on Neck/head		Venereal Disease	Unexplained weight loss
Hearing Aid		Pacemaker	Heart Attack
Heart Murmur		Mitral Valve Prolapse	Heart Stents

Recent Surgeries Dates _____

Have you ever needed Pre-Medication Antibiotic Prior to Dental Treatment? YES/NO

Allergies _____

Allergic to Latex YES/NO

Allergic to Penicillin YES/NO

List Prescription Medications:

Pharmacy Name _____ Phone # _____

Herbal Supplements _____

Are you Pregnant? YES/NO

Due Date _____

Nursing YES/NO

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