JOHN V. REITZ., DDS
30 COMMERCE DRIVE, SUITE 2
READING PA 19610

(610)320-9993
jreitz@reitzdds.com
www.reitzdds.com

Medical & Dental History Form

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Chart # _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____
_____ (City) _____ (State) _____ (Zip Code)

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

Do you have a pacemaker, an artificial heart valve, or been diagnosed with mitral valve prolapse?

◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

_____

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Your Primary Care Physician's name, address, & phone number:

Are you taking any medication or substances?

◯ Yes ◯ No

If you have answered yes, please list:

Please mark any of the following to indicate Yes in response to the question:

- ☐ Have you ever had complications following dental treatment?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Are you currently taking any prescription or non-prescription medications?
- ☐ Do you require the use of corrective lenses (contacts or glasses)?
- ☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date? _____

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Have you ever had a serious illness or major surgery? If so please explain...

Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood or osteoporosis?

◯ Yes ◯ No

Please indicate if you have experienced any of the following:

☐ *PreMed	☐ Acid Reflux	☐ Allergies	☐ Amoxicillin Allergy
☐ Anemia	☐ Antidepressants	☐ Antihistimines Aller	☐ Arthritis
☐ Artificial Joints	☐ Asthma	☐ Benzocaine	☐ Bisphosphonates
☐ Blood Thinners/other	☐ Blood thinners	☐ Cancer	☐ Chemotherapy
☐ Clindamycin Allergy	☐ Codeine Allergy	☐ Dementia	☐ Diabetes
☐ Dizziness	☐ Down Syndrome	☐ Drug/AL. addictions	☐ Epilepsy
☐ Erythromycin Allergy	☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma
☐ Hay Fever	☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis
☐ High Blood Pressure	☐ HIV	☐ Hyperthyroid	☐ Ibuprofen Allergy
☐ Jaundice/liver dis.	☐ Kidney Disease	☐ Latex Allergy	☐ Local Anes. Allergy
☐ Mental Disorders	☐ Motrin allergy	☐ Multiple Sclorosis	☐ Nervous Disorders
☐ Other	☐ Penicillin Allergy	☐ Prednisone Allergy	☐ Pregnancy
☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Sinus Problems	☐ Smoker/Chew	☐ Steroids Allergy	☐ Stop Coumidin
☐ Stroke	☐ Sulfa allergy	☐ Talwin Allergy	☐ Tetracycline allergy
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Venereal Disease

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Do you require antibiotics before dental treatment?

◯ Yes ◯ No

Have you ever had or have pain in your jaw joint?

◯ Yes ◯ No

Have you ever had cold sores or fever blisters?

◯ Yes ◯ No

Do you bruise easily?

◯ Yes ◯ No

Have you ever bled excessively after being cut or injured?

◯ Yes ◯ No

Have you had psychiatric treatment?

◯ Yes ◯ No

Have you taken any prescription drugs Fenfluramine, Fenfluramine combined with Phentermine (Fen-Phen), Dexfenfluramine (Redux), or other weight loss products?

◯ Yes ◯ No

Have there been injuries to your face, mouth or chin?

◯ Yes ◯ No

Do you have any disease, condition or problem not listed? If so explain...

Is there anything else we should know about your health that we have not covered in this form?

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☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____