Blooming Smiles Dental 534 N. Broad Street Lansdale, PA 19446 215-412-3336

Name _____ Date of birth _____

Medical History

Have you ever had any of the following? Please check all those that apply:

AIDS	yes __ no __	Heart Disease	yes __ no __
Anemia	yes __ no __	Heart Murmur	yes __ no __
Arthritis	yes __ no __	High Blood Pressure	yes __ no __
Artificial Joints	yes __ no __	Hepatitis	yes __ no __
Asthma	yes __ no __	Kidney Disease	yes __ no __
Blood Disease	yes __ no __	Liver Disease	yes __ no __
Cancer	yes __ no __	Mental Disorders	yes __ no __
Diabetes	yes __ no __	Nervous Disorders	yes __ no __
Dizziness	yes __ no __	Pacemaker	yes __ no __
Epilepsy	yes __ no __	Radiation Treatment	yes __ no __
Excessive Bleeding	yes __ no __	Respiratory Problems	yes __ no __
Fainting	yes __ no __	Rheumatic Fever	yes __ no __
Glaucoma	yes __ no __	Rheumatism	yes __ no __
Head Injuries	yes __ no __	Sinus Problems	yes __ no __
Stomach Problems	yes __ no __	Stroke	yes __ no __
Tuberculosis	yes __ no __	Tumors	yes __ no __
Ulcers	yes __ no __	Venereal Disease	yes __ no __

Are you currently taking any medications? Yes__ No __
If yes, please list: _____

Do you have any allergies to medications or foods? Yes __ No __
If yes, please explain: _____

Have you ever been tested for the Human Pappillomavirus (HPV)? Yes___ No ___
If yes, please explain: _____

Are you pregnant? Yes __ No __

Have you been admitted to a hospital or needed emergency care during the past 2 years?
If yes, please explain: _____

Do you smoke or use tobacco products? Yes __ No __
If yes, what type of product & how often: _____

Do you drink alcohol? Yes __ No __
If yes, how much & how often: _____

Have you ever had complications following dental treatment? Yes __ No __
If yes, please explain: _____

Personal Information

Name: _____ Social Security #: _____

Address: _____ City: _____ Zip: _____

_____

Home phone number: _____ Work phone number: _____
Cell phone number: _____ Email address: _____

Primary Care Physician: _____ Phone: _____
Are you under the care of a physician currently for any medical problems? Yes __ No _
If yes, please explain:_____

Employment Information

Employer name: _____ Occupation: _____

Address: _____

Insurance Information

Name of Insured: _____ Insured social security # _____
Insured's date of birth: _____
Insured address, if different from above address:_____
_____
Insured's Employer Name _____
Insured's Employer Address: _____

Insurance Plan name: _____
ID# _____ Group # _____

Cancellation of Appointments

You are required to give the office at least 24 hours notice that you will not be able to keep your appointment. If less than 24 hours notice is given or you do not show up for your appointment there will be a fee of $50.00 charged to your account.

_____ Date _____

Signature of patient, parent, or guardian

Consent for services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

I understand that the fee estimate listed for dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within thirty (30) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Also to the best of my knowledge all of the preceding answers and information provided are true and correct. If ever I have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of patient, parent, or guardian

If patient is a minor, please indicate relationship to patient: _____

Blooming Smiles Dental
Michelle Yilanjian, D.M.D.
534 North Broad Street
Lansdale, PA 19446