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| **ADULT PRE-CLINICAL HISTORY** | |
| [http://ts4.mm.bing.net/images/thumbnail.aspx?q=1604082076999&id=5a7cc496e778ba8e2fcc6e6c84322f84&url=http%3a%2f%2f4.bp.blogspot.com%2f_9AMxAVZ-5hI%2fR0IORjbVRnI%2fAAAAAAAAABs%2fSzWz5Y4f-9c%2fs320%2fImage15.jpg](http://www.bing.com/images/search?q=greek+architecture+pictures#focal=9413193ef45e894244b28aa87560e714&furl=http://4.bp.blogspot.com/_9AMxAVZ-5hI/R0IORjbVRnI/AAAAAAAAABs/SzWz5Y4f-9c/s320/Image15.jpg)  **DOREEN E. GUNDER, DDS**  *We are happy to have you join our family of patients and friends. The benefits of a healthy, beautiful smile are immeasurable, and our goal is to help you to achieve the attractive and healthy smile you want and deserve. Please complete this form so that we may provide the best care possible for you. Thank you!* | **ABOUT YOU** Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [] Female [] Male  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_  Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Confirmation: [] Home [] Cell [] Work [] Email  Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Birth date: \_\_\_\_\_ /\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_ Marital Status: [] Single [] Married [] Widowed  Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name(s) of Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How do you enjoy spending your free time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Who can we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **EMERGENCY INFORMATION**  Person to contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **PRIMARY DENTAL INSURANCE INFORMATION**  Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID # / SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber’s Birth Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Subscriber’s SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber’s relation to you: [] Self [] Spouse [] Parent [] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **SECONDARY DENTAL INSURANCE INFORMATION**  Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID # / SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber’s Birth Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Subscriber’s SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber’s relation to you: [] Self [] Spouse [] Parent [] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I agree to be responsible for all charges for dental services and materials not paid for by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted under applicable law. I authorize release of information relating to this claim. I also authorize payment of dental benefits, otherwise payable to me, to be paid directly to:  *Doreen E. Gunder, DDS, LLC.* Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

2120 Fisher Road, Mechanicsburg, PA 17055 ◊ 717.795.9392 phone ◊ 717.795.5494 fax ◊ [office@doreengunder.comcastbiz.net](mailto:office@doreengunder.comcastbiz.net)

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| **ADULT PRE-CLINICAL HISTORY** | |
| **BASIC HEALTH INFORMATION:**  Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current Health Condition: [] Excellent [] Good [] Fair [] Poor  Have you had any serious health problems in the last 5 years? [] Yes [] No  If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you currently pregnant (women)? [] Yes (How many months? \_\_\_\_\_) [] No  Please list all prescription medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  cont. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please list all vitamins/herbal supplements:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  cont. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you know your blood pressure? [] Yes (What is it approximately? \_\_\_\_\_\_\_\_) [] No  Do you smoke? [] Yes (How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ) [] No | **ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:**  [] Local Anesthetics  [] Penicillin  []Other Antibiotic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  [] Barbiturates, sedatives, sleeping pills  [] Sulfa Drugs  [] Aspirin  [] Shellfish, Iodine, Red Wine  [] Codeine / Other Narcotics  [] Latex  [] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**DO YOU HAVE, OR HAVE HAD, ANY OF THE FOLLOWING:**

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| [] AIDS/HIV Positive  [] Alzheimer’s Disease  [] Anaphylaxis  [] Arthritis/Gout  [] Artificial Heart Valve  [] Artificial Joint: \_\_\_\_\_\_\_\_\_\_\_\_\_  [] Asthma  [] Blood Disorder: \_\_\_\_\_\_\_\_\_\_\_\_  [] Blood Transfusion  [] Breathing Problem  [] Bruise Easily  [] Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  [] Chemotherapy  [] Chest Pain  [] Congenital Heart Disorder  [] Convulsions | [] Diabetes  [] Drug Addiction  [] Easily Winded  [] Emphysema  [] Epilepsy/Seizures  [] Excessive Bleeding  [] Excessive Thirst  [] Fainting Spells/Dizziness  [] Frequent Cough  [] Frequent Diarrhea  [] Frequent Headaches  [] Glaucoma  [] Hay Fever  [] Heart Attack/Failure  [] Heart Murmur  [] Heart Pace Maker | [] Heart Trouble/Disease  [] Hemophilia  [] Hepatitis A  [] Hepatitis B or C  [] High Blood Pressure  [] Hives or Rash  [] Hypoglycemia  [] Irregular Heartbeat  [] Kidney Problems/Disease  [] Leukemia  [] Liver Disease  [] Low Blood Pressure  [] Lung Disease  [] Mitral Valve Prolapse  [] Pain in Jaw Joints  [] Psychiatric Care | [] Radiation Treatments  [] Recent Weight Gain/Loss  [] Renal Disease  [] Rheumatic Fever  [] Rheumatism  [] Scarlet Fever  [] Shingles  [] Sickle Cell Disease  [] Sinus Trouble  [] Stomach/Intestinal Disease  [] Stroke  [] Thyroid Disease  [] Tuberculosis  [] Ulcers |

**HAVE YOU HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? IF YES, PLEASE EXPLAIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**DENTAL HISTORY:** On a scale of 1 to 5 (1 being low/poor and 5 being high/good) please rate the following:

How do you feel your overall dental health is?............................................................................... 1 2 3 4 5

Over the last 10 years, how faithfully have you had your teeth cleaned?...................................... 1 2 3 4 5

What is you level of sensitivity to dental procedures?.................................................................... 1 2 3 4 5

How do you feel about your smile and the look of your teeth?...................................................... 1 2 3 4 5

Date of your last hygiene (cleaning) visit: \_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **What is the main reason for your visit today?**  [] Experiencing tooth pain  [] I need a check-up  [] Cleaning  [] Interested in orthodontics  [] Teeth Whitening  [] Cosmetic Dentistry  [] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **I would like to learn more about:**  [] Orthodontics  [] Dentures  [] Implants  [] Bridges  [] Veneers  [] Teeth Whitening  [] Cosmetic Dentistry  [] Botox and Dermal fillers  [] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Have you ever been treated for TMJ?  [] Yes [] No  Have you ever or do you suffer from headaches?  [] Yes [] No  Do you ever experience tension headaches?  [] Yes [] No  Do you ever experience migraine headaches?  [] Yes [] No  Do you get muscle tenderness in your jaw or neck?  [] Yes [] No |

If a health care worker is exposed to my blood or bodily fluids through a needle stick, cut or splash to the eye or mouth, I agree to have my blood tested for blood-borne diseases to include Hepatitis B and C Virus and Human Immunodeficiency Virus (AIDS). Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information I have given is true and accurate to the best of my knowledge.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_