



AMY SHOUMER DMD

919 Conestoga Rd
Bldg ne Suite 100,
Bryn Mawr, PA 19010
dramyshoumer.com
610-234-3881

PATIENT INFORMATION:

Today's Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ P.O. Box/Apt. #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Social Security #: _____

Email: _____ I prefer communications via ☐ E-mail ☐ Text (select one or both)

MEDICAL INFORMATION

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive.

Are you under a physician's care now? ☐ Yes ☐ No Explain: _____

Have you been hospitalized or had a major operation? ☐ Yes ☐ No Explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No Explain: _____

Have you ever taken Fosamax, Boniva, Actonel
or any other medications containing Bisphosphonates? ☐ Yes ☐ No Explain: _____

Are you on a special diet? ☐ Yes ☐ No Explain: _____

Do you use tobacco or do you vape? ☐ Yes ☐ No Explain: _____

Do you use controlled substances? ☐ Yes ☐ No Explain: _____

Do you drink alcoholic beverages? ☐ Yes ☐ No How much?: _____

Doctor's Name: _____ Phone: _____

List of Medications currently taking: _____

Joint Replacement

☐ Yes ☐ No Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

If Yes, Date: _____ Doctor: _____

Were there any complications? _____

☐ Yes ☐ No Since 2001, were you, treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, Multiple Myeloma or metastatic cancer?

Date treatment began: _____

Please specify the reaction:

Allergies: Are you allergic or sensitive to any of the following?

☐ Yes	☐ No	Local anesthetics:	_____
☐ Yes	☐ No	Aspirin:	_____
☐ Yes	☐ No	Penicillin or other antibiotics	_____
☐ Yes	☐ No	Barbiturates, Sedatives, or sleeping pills:	_____
☐ Yes	☐ No	Sulfa Drugs:	_____
☐ Yes	☐ No	Codeine or other Narcotics:	_____
☐ Yes	☐ No	Metals:	_____
☐ Yes	☐ No	Latex (Rubber):	_____
☐ Yes	☐ No	Hay fever/Seasonal:	_____
☐ Yes	☐ No	Animals:	_____
☐ Yes	☐ No	Food:	_____
☐ Yes	☐ No	Other: _____	_____

Do you have or have you **ever had any of the following? (Please check all that apply and specify if necessary)**

☐ AIDS/HIV Positive	☐ Frequent Cough	☐ Osteoporosis
☐ Abnormal Bleeding	☐ Frequent Diarrhea	☐ Pain in jaw joints
☐ Alzheimer's Disease	☐ Frequent Headaches	☐ Parathyroid Disease
☐ Anaphylaxis	☐ Fainting spells/Dizziness	☐ Persistent swollen glands in neck
☐ Anemia	☐ Gastrointestinal Disease	☐ Psychiatric Care
☐ Angina	☐ GE Reflux/Heartburn	☐ Radiation Treatments
☐ Arteriosclerosis	☐ Genital Herpes	☐ Recent Weight Loss
☐ Arthritis/Gout	☐ Glaucoma	☐ Recurrent Infections
☐ Artificial Heart Valve	☐ Hay Fever	Type of Infection:
☐ Artificial Joint	☐ Heart Attack/Failure	
☐ Asthma	☐ Heart Murmur	☐ Rapid Weight Loss
☐ Autoimmune Disease	☐ Heart Pacemaker	☐ Renal Dialysis
☐ Blood Disease	☐ Heart Trouble/Disease	☐ Rheumatic Fever
☐ Blood Transfusion	☐ Hemophilia	☐ Rheumatic Heart Disease
☐ Breathing Problems	☐ Hepatitis A	☐ Rheumatism
☐ Bronchitis	☐ Hepatitis B or C	☐ Rheumatoid Arthritis
☐ Bruise Easily	☐ Herpes	☐ Scarlet Fever
☐ Cancer	☐ High Blood Pressure	☐ Sexually Transmitted Disease
☐ Cardiovascular Disease	☐ High Cholesterol	☐ Sickle Cell Disease
☐ Chemotherapy	☐ Hives or Rash	☐ Sinus Trouble
☐ Chest Pains	☐ Hypoglycemia	☐ Sleep Disorder
☐ Cold Sores/Fever blisters	☐ Irregular Heartbeat	☐ Spina Bifida
☐ Congenital Heart Defect	☐ Kidney Problems	☐ Shingles
☐ Convulsions	☐ Leukemia	☐ Stomach/Intestinal Disease
☐ Cortisone Medication	☐ Liver Disease	☐ Stroke
☐ Congenital Heart Defect	☐ Low Blood Pressure	☐ Swelling in Limbs
☐ Damaged Heart Valves	☐ Lung Disease	☐ Systemic Lupus Erythematosus
☐ Diabetes	☐ Malnutrition	☐ Thyroid Disease
☐ Drug Addiction	☐ Mental Health disorders	☐ Tonsillitis
☐ Easily Winded	Specify:	☐ Tuberculosis
☐ Eating Disorder		☐ Tumors or Growths
☐ Emphysema	☐ Mitral Valve Prolapse	☐ Ulcers
☐ Epilepsy or Seizures	☐ Migraines	☐ Venereal Disease
☐ Excessive Bleeding	☐ Night sweats	☐ Yellow Jaundice
☐ Excessive Thirst	☐ Neurological Disorders	
☐ Excessive Urination	Specify:	

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please specify: _____

WOMEN:

Are you pregnant? ☐ Yes ☐ No Trying to get pregnant? ☐ Yes ☐ No Taking Oral Contraceptives? ☐ Yes ☐ No

DENTAL INFORMATION

- Do your gums bleed when you brush or floss? ☐ Yes ☐ No
- Are your teeth sensitive to cold, hot, sweets, or pressure? ☐ Yes ☐ No
- Does food or floss catch between your teeth? ☐ Yes ☐ No
- Is your mouth dry? ☐ Yes ☐ No
- Have you had any periodontal (gum) treatments? ☐ Yes ☐ No
- Have you ever had orthodontic (braces) treatment? ☐ Yes ☐ No
- Have you had any problems associated with previous dental treatments? ☐ Yes ☐ No
- Is your home water supply Fluoridated? ☐ Yes ☐ No
- Do you drink bottled or filtered water? ☐ Yes ☐ No
- If so, how often? (Please check) ☐ Daily ☐ Weekly ☐ Occasionally
- Do you have any earaches or neck pains? ☐ Yes ☐ No
- Do you have any clicking, popping or discomfort in the jaw? ☐ Yes ☐ No
- Do you brux or grind your teeth? ☐ Yes ☐ No
- Do you have sores or ulcers in your mouth? ☐ Yes ☐ No
- Do you wear dentures or partials? ☐ Yes ☐ No
- Do you participate in active recreational activities? ☐ Yes ☐ No
- Have you ever had a serious injury to your head or mouth? ☐ Yes ☐ No

SLEEP QUALITY

- Do you snore? ☐ Yes ☐ No
- Has your partner / spouse or anyone else told you that you snore and keep them from sleeping comfortably? ☐ Yes ☐ No
- Has anyone told you that you stop breathing for a few seconds while you are sleeping? ☐ Yes ☐ No
- Do you have a CPAP machine? ☐ Yes ☐ No
- Do you have sleep apnea? ☐ Yes ☐ No

What is your home care routine (i.e., electric toothbrush, floss, etc)? _____

Date of last dental exam? _____ Date of last dental x-rays? _____

What was done at that time?

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No

If yes, please explain: _____

What is the reason for your dental visit today?

SMILE EVALUATION

- Are you missing any teeth? ☐ Yes ☐ No
- Do you see any pitting or defects on the surface of your teeth? ☐ Yes ☐ No
- Are the edges of any teeth worn down, chipped, uneven? ☐ Yes ☐ No
- Do any of your teeth appear too small, short, large or long? ☐ Yes ☐ No
- Do you have any prior dental work that appears unnatural? ☐ Yes ☐ No
- Do you have any crowns or bridges that appear dark at the edge of your gums? ☐ Yes ☐ No
- Do you have a "gummy" smile (too much of your gums show when smiling)? ☐ Yes ☐ No
- Are your gums red, sore, puffy, bleeding, or receded? ☐ Yes ☐ No
- Are you self-conscious about your teeth or smile? ☐ Yes ☐ No
- Would you like to change anything about the appearance of your teeth or smile? ☐ Yes ☐ No

If you answered YES to ANY of the questions above, there are often several alternatives to improve your teeth and smile. You can have the smile you've always wanted!

We feel it is necessary to develop a rapport with our patients. Many new patients have had a past unpleasant dental experience. We are committed to taking the time to get to know you, discuss your concerns, your fears, and your dental expectations.

Please place a check mark in the box next to any statements that concern you:.

- ☐ I gag easily
- ☐ I feel out of control when I'm lying down for a long time, and I feel uncomfortable about what you will say about my teeth and hygiene.
- ☐ Pain relief is a top priority for me
- ☐ I don't like shots (or I've had a bad reaction to shots)
- ☐ Please tell me what I need to know about my mouth in order to make an informed decision
- ☐ My teeth are very sensitive
- ☐ I don't like the sound of that tool that makes the picking and scraping noise. It is like someone is scratching fingernails on a blackboard
- ☐ I don't like cotton in my mouth
- ☐ I hate the noise of the drill
- ☐ Please respect my time, I do not want to be left sitting in the reception area
- ☐ I want to know the cost up front
- ☐ I have difficulty listening and remembering what I hear while sitting in the dental chair
- ☐ I have health problems and questions that we need to discuss

DENTAL BENEFITS INFORMATION

POLICY HOLDER INFORMATION (IF NOT YOURSELF):

First Name: _____ Middle: _____ Last Name: _____ Home Tel: _____

Address: _____ P.O. Box/Apt. #: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Birth Date: _____ Social Security #: _____ Relationship to Patient: _____

PRIMARY INSURANCE INFORMATION:

Name of Insurance: _____ Employer Group #: _____ ID#: _____

Employer: _____

DO YOU HAVE SECONDARY INSURANCE ? Yes No

Partnership Pact:

I ask that you honestly inform me of all my dental problems. I want you to make me aware of the best quality dentistry available today. Then we can discuss how I can make healthy choices that will work within my budget. I also want to know all the pain relief options available to me, how each dental procedure will work, and how much of my time will be required.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient/parent/or guardian: _____ Date: _____