

DENTAL ASSOCIATES OF HERSHEY

DAVID L. MORGAN, D.D.S.
CHRISTINE A. HIGGINS, D.M.D.

LLOYD A. MORGAN, D.D.S.
JOHN V. GUSTAFSON, D.M.D.

Name _____ Birthdate _____ Today's Date _____

Address _____ City _____ Zip _____

Telephone Home # _____ Work # _____ Cell# _____

E-mail address _____

Dental Insurance _____ SS# _____

Place of Employment _____

Physician's Name _____ Telephone# _____

Please Circle Proper Answer for Each Question

1. Are you in Pain?----- Yes or No
2. Have you ever had severe bleeding after cuts or extraction of teeth?----- Yes or No
3. Are you under the care of a physician at the present time?----- Yes or No
4. Are you taking medication at the present time?----- Yes or No
5. Are you allergic to any drugs?----- Yes or No
6. Are you allergic to any local anesthesia such as Novocain, xylocaine, ect?-----Yes or No
7. Are you on a special diet?----- Yes or No
8. Has your Medical Doctor ever said you have cancer or a tumor?----- Yes or No
9. Do you have any disease, condition, or problem not listed?----- Yes or No
10. Women: Are you pregnant now?----- Yes or No

Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	AIDS
Heart Disease/Attack	Cough	Hepatitis A (Infectious)
Angina Pectoris	Tuberculosis (TB)	Hepatitis B (Serum)
High Blood Pressure	Asthma	Liver Disease
Heart Murmur	Hay Fever	Yellow Jaundice
Rheumatic Fever	Sinus Trouble	Blood Transfusion
Congenital Heart Lesions	Allergies or Hives	Drug Addiction
Scarlet Fever	Diabetes	Hemophilia
Mitro Valve Prolapse	Thyroid Disease	Venereal Disease
Artificial Heart Valve	X-ray or Cobalt Treatment	Cold Sore
Heart Surgery	Chemotherapy (Cancer/Leukemia)	Genital Herpes
Heart Pacemaker	Arthritis	Epilepsy or Seizures
Artificial Joint	Rheumatism	Fainting or Dizzy Spells
Anemia	Cortisone Medicine	Nervousness
Stroke	Glaucoma	Psychiatric Treatment
Kidney Trouble	Pain in Jaw Joints	Sickle Cell Disease
Ulcers	Bruise Easily	HIV Positive

Patient, Parent or Guardian Signature _____