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Personalized Restorative and Cosmetic Dentistry  
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**PATIENT INFORMATION**

NAME \_\_\_\_\_  
 single  married  divorced  separated  widowed  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone \_\_\_\_\_  
e-mail address \_\_\_\_\_  
Cell phone \_\_\_\_\_  
Date of birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Employed by \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Business phone \_\_\_\_\_  
Present position \_\_\_\_\_

How long held? \_\_\_\_\_  
Name of spouse \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Employed by \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Business phone \_\_\_\_\_  
Present position \_\_\_\_\_  
How long held? \_\_\_\_\_  
Who can we thank for referring you to our office?  
\_\_\_\_\_  
Who will be responsible for this account?  
\_\_\_\_\_

**MEDICAL HISTORY**

Physician's name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_  
Date of last physical exam \_\_\_\_\_  
List any medications you are currently taking including birth control pills: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have or have you had any of the following? Please indicate with a check mark.

- Heart Trouble
  - heart murmur
  - pacemaker
  - valve replacement
  - other \_\_\_\_\_
- Low/High Blood Pressure
- Circulatory Problems
- Emotional Problems
- Radiation Treatments
- Excessive Bleeding
- AIDS/HIV

- Any allergies to
    - antibiotics
    - environmental
    - other \_\_\_\_\_
    - anesthetics
    - pain medications
  - Anemia
  - Asthma
  - Hepatitis
  - Joint Replacement
  - Psychiatric Care
  - Scarlet Fever
  - Stroke
  - Tuberculosis
  - Sexually transmitted disease
  - Arthritis
  - Diabetes
  - Herpes
  - Malignancies
  - Rheumatic Fever
  - Sinus Problems
  - Tonsillitis
  - Ulcer
- Do you use tobacco?  yes  no  
 cigarette  cigar  pipe  smokeless tobacco
- Are you pregnant?  Yes  no What month \_\_\_\_\_  
Obstetrician \_\_\_\_\_  
Phone \_\_\_\_\_

\_\_\_\_\_  
**Patient signature/date**