Dr. Gordon Roeder & Dr. Zachary Kulp
1326 West Broad Street, Quakertown, PA 18951
www.dream-dentistry.com
215-538-1109

Dream Dentistry & Sleep Care™
EXPERIENCE THE EXCEPTIONAL

Date _____ Email _____

Patient Name _____ Street Address _____

Birthdate _____ City _____

Social Security # _____ State / Zip Code _____

Cell Phone _____ Employer Name _____

Home Phone _____ Employer Address _____

Work Phone _____

Whom may we thank for referring you? _____

Person Responsible for Payment (if different from above) _____

Address _____
Street City State Zip

Relationship to Patient _____

Social Security # _____

Birthdate _____

Driver's License # _____

Home Phone _____

Work Phone _____

Employer _____

Patient's Parent(s) Name (if patient is a minor)

Father: _____
First Name Last Name

Mother: _____
First Name Last Name

Patient's Spouses Name _____
First Name Middle Name Last Name

Spouses Employer _____ Work Phone _____

DENTAL INSURANCE INFORMATION

Insured's Name (Employee) _____ Insured's Social Security # _____

Insured's Birthdate _____

Insured's Address _____
Street City State Zip

Insured's Employer _____ Insurance ID # _____

Insurance Company Name _____ Group # _____

Insurance Address _____

EMERGENCY INFORMATION

Local Friend or Relative Not Living With You _____ Phone # _____

Complete Address _____
Street City State Zip

FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistant as he deems fit.
I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff.
I agree to pay for all service rendered by this office.

_____
SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP DATE

MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years?..... ☐ Yes ☐ No

If yes, for what reason? _____

Please provide the name, address, and telephone number of your physician:

_____

Physician Name | Address | Phone Number

Are you having dental problems at this time?..... ☐ Yes ☐ No

Do your gums bleed at any time?..... ☐ Yes ☐ No

Do you feel nervous about having dental treatment?..... ☐ Yes ☐ No

Have you ever had a bad experience in a dental office?..... ☐ Yes ☐ No

Have you been a patient in a hospital during the last two years?..... ☐ Yes ☐ No

If yes, please _____

Have you taken any medicine or drugs during the past two years?..... ☐ Yes ☐ No

Are you allergic to (i.e. itching, rash, swelling of hands, feet, or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications?..... ☐ Yes ☐ No

Is so, what? _____

Have you ever had excessive bleeding requiring special treatment?..... ☐ Yes ☐ No

☐ Heart Problem	☐ Emphysema	☐ Pace Maker
☐ Abnormal Bleeding	☐ Epilepsy	☐ Psychiatric Treatment
☐ Alcohol Abuse	☐ Fainting Spells	☐ Radiation Therapy
☐ Allergies	☐ Frequent Headaches	☐ Rheumatic Fever
☐ Anemia	☐ Glaucoma	☐ Seizures
☐ Angina Pectoris	☐ Heart Surgery	☐ Sickle Cell Disease
☐ Artificial Heart	☐ Hemophilia	☐ Sinus Problems
☐ Asthma	☐ Hepatitis A, B, C	☐ Stroke
☐ Blood Transfusion	☐ High Blood Pressure	☐ Thyroid Problems
☐ Cancer-Chemotherapy	☐ HIV/AIDS	☐ Tuberculosis (TB)
☐ Colitis	☐ Kidney Problems	☐ Ulcers
☐ Diabetes	☐ Liver Disease	☐ Venereal Disease
☐ Difficulty Breathing	☐ Low Blood Pressure	☐ Yellow Jaudice
☐ Drug Abuse	☐ Mitral Valve/Heart Murmur	

Are you a smoker?..... ☐ Yes ☐ No

Do you use or have you ever used recreational drugs? ☐ Yes ☐ No

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breathe or because you are very tired?... ☐ Yes ☐ No

Do you ever wake up from sleep short of breath?..... ☐ Yes ☐ No

Has your medical doctor ever said you have cancer or a tumor?..... ☐ Yes ☐ No

Women Are you pregnant? ☐ Yes ☐ No

If yes, what month are you due? _____

Are you taking birth control pills?..... ☐ Yes ☐ No

Do you have a disease, condition, or problem not listed? If yes, please list: ☐ Yes ☐ No

COMMENTS

LIST MEDICATIONS

_____

_____

_____

_____

_____

_____

How do you feel about maintaining a healthy mouth? _____

How do you feel about the appearance of you teeth? _____