MaryBeth Marcincin, D.M.D., M.S.
1414 Millard St.
Bethlehem, PA 18018

MEDICAL HISTORY FORM

Date: _____ Patient #: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____
Preferred Name: _____ Birth Date: _____ Age:_____ □Male □Female
Address: _____
City/State: _____ Zip: _____ Phone #: _____
School: _____ Grade: _____
Referred by: _____

MEDICAL CONTACT INFORMATION

Dentist Name: _____ Last Cleaning: _____
Physician Name: _____ Last Physical: _____
Other Doctors/Specialists: _____

Parent/Guardian #1:
Last Name: _____ First Name: _____ Birth Date: _____
Phone #: _____
Address If Different than Patient: _____
Employer: _____ Occupation: _____

Parent/Guardian #2:
Last Name: _____ First Name: _____ Birth Date: _____
Phone #: _____
Address If Different than Patient: _____
Employer: _____ Occupation: _____

DENTAL INSURANCE INFORMATION

Dental Insurance Carrier: _____
Insurance Claims Address: _____
Name of Subscriber: _____
Subscriber Birth Date: _____ Subscriber ID/SSN: _____

SECONDARY DENTAL INSURANCE INFORMATION

Dental Insurance Carrier: _____
Insurance Claims Address: _____
Name of Subscriber: _____
Subscriber Birth Date: _____ Subscriber ID/SSN: _____

MEDICAL HISTORY

Now, or in the past, has the patient had:

☐Birth Defects/Hereditary Problems
☐Bone Fractures/Major Accidents
☐Rheumatoid/Arthritic Conditions
☐Endocrine/Thyroid Conditions
☐Kidney Problems
☐Diabetes
☐Cancer/Tumor
☐Radiation/Chemotherapy
☐Stomach Ulcer
☐Polio, Mononucleosis, Pneumonia
☐AIDS or HIV
☐Hepatitis, Jaundice, Liver Problems
☐Fainting Spells, Seizures, Epilepsy
☐Sensory or Speech Difficulties
☐Recent Weight Loss, Poor Appetite
☐History of Eating Disorder (anorexia, bulimia)
☐Anemia/Bleeding Disorder
☐High or Low Blood Pressure
☐Heart Problems
☐Skin Disorder
☐Special Diet
☐Ear, Nose, or Throat Condition
☐Hay Fever, Asthma, Sinus Trouble or Hives
☐Psychiatric Care
☐Smoke or Chew Tobacco
☐Asperger's
☐Autism
☐ADHD
☐Concussion

Allergies or Reactions to the Following:

☐Anesthesia (Novocain/Lidocaine)
☐Aspirin
☐Ibuprofen (Motrin/Advil)
☐Penicillin or other Antibiotics
☐Sulfa Drugs
☐Codeine/Other Narcotics
☐Metal (jewelry, nickel)
☐Latex (gloves, balloons)
☐Vinyl/Acrylic
☐Other Substances (please specify)
_____
_____

Females: Has the patient begun menstruation? _____
If so, approximately when? _____

Males: Has the patient begun puberty? _____

List any medications the patient is currently taking:
_____
_____
_____

Has the patient ever responded adversely to medical or dental treatment? If Yes, please explain:
_____
_____
_____

If you have answered **YES** to any of the above please specify: _____
_____

Does the patient have any other medical conditions? _____
_____

The above information is accurate and complete to the best of my knowledge. I understand that the information provided is only for use in my treatment, billing and processing of insurance benefits, which I am entitled to. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. I understand that it is my responsibility to inform the practice of any changes to the history record or medical/dental status.

Signature: _____ Date: _____

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1414 Millard Street
Bethlehem, PA 18018
610.691.1461

PRIVACY CONSENT FORM

Your protected health information (i.e. individually identifiable information such as names, dates, phone/fax numbers, email addresses, home address, social security numbers, and demographic data) may be used in connection with your treatment, payment of your accounts or health care operation (i.e. performance reviews, certification, accreditation and licensure).

Please provide the names of any individuals not listed in the parent/guardian section of the medical history form to which the patient's information may be released (i.e. stepparent, grandparent, aunt/uncle).

Name:	Phone Number:
_____	_____
_____	_____
_____	_____
_____	_____

You have the right to review our office's privacy notice prior to signing this consent form. If you wish to review this form, please ask a front desk staff member to provide you with a copy.

You have the right to request restriction on the use of your protected health information, though we are not required to and may not honor your request.

You may revoke this consent at any time. Please ask a staff member for a copy of the Privacy Consent Revocation Form.

Thank you for your cooperation. Please let us know if you have any questions.

Patient/Guardian Signature: _____
Print Name: _____ Date: _____