Dr. Harvey Levy & Associates, P.C.
198 Thomas Johnson Drive, Suite 108, Frederick, MD 21702
Office: (301) 663-8300 Fax: (301) 682-3993 E-mail:drhlevyassoc@gmail.com

Personal Information

Patient's Name: ______________________________ Nickname: __________
Last First MI Mr. Ms. Mrs. Dr.

Date of Birth: ____/____/______ SSN: _____-____-_____ ☐Single ☐Married ☐Child ☐Other

Home Address: ______________________________
Street City State Zip

Home Ph: (____)__________ Cell Ph: (____)__________ Work Ph: (____)__________ Preferred #: ☐H ☐C ☐W

E-mail: ______________________ **Referred By:** ______________________

Employer/School: ______________________ **Occupation:**______________ How long there? ______

Work/School Address: ______________________________
Street City State Zip

Spouse's or Parent's Information

Name:______________________ Relation:______________ Ph: (____)__________

Employer: ______________________ Title:______________ How long there? ______

Name:______________________ Relation:______________ Ph: (____)__________

Employer: ______________________ Title:______________ How long there? ______

Emergency Contact

Name:______________________ Relation:______________ Ph: (____)__________

Person financially responsible for account if other than yourself

Name:______________________ Relation:______________ Ph: (____)__________

Address: ______________________________
Street City State Zip

Dental History

Most recent cleaning? __________ Most recent visit? __________ What was done? __________

Previous Dentist:______________________ City, State: ______________ Ph: (____)__________

How often do you brush? ________ Floss? ______ Any additional hygiene aids? __________

Have you ever had any of the following conditions?

Y N Bleeding Gums	Y N Tired Jaws	Y N Periodontal (Gum) Treatment
Y N Tender/Swollen Gums	Y N Clenching Teeth	Y N Endodontic (Root Canal) Treatment
Y N Loose Teeth	Y N Burning Tongue	Y N Complicated Extraction
Y N Sensitive Teeth	Y N Sinus Conditions	Y N Crown (Cap) or Bridge
Y N Mouth Sores	Y N Fear of Dentistry	Y N Removable Dentures
Y N Pain in Mouth	Y N Sedation for Dental Work	Y N Dental Implants
Y N Ear Ache	Y N Orthodontic (Braces) Treatment	Y N Oral Habits ______________

Please describe any unusual dental experience: ______________________________

Please list any medication you need to take prior to dental work: ______________________________

Medical History

Last Visit to Physician:____________ Reason: ______________________________

Physician's Name:________________________ City, State:_____________________ Ph: ( ) __________

What drugs or medications are you taking now and why? ______________________________

Women: Are you currently pregnant? ________ If so, how many weeks? ___________________

Have you ever had any of the following conditions?

Y N Rheumatic Fever
Y N Heart Murmur/Condition
Y N Pacemaker/Other Device
Y N Prolonged Bleeding
Y N Herpes I or II
Y N AIDS/HIV
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Cancer/Malignancy/Tumor
Y N Artificial Joint/Rod

Y N Deaf/Hard of Hearing
Y N Diabetes
Y N Epilepsy/Seizures
Y N Tuberculosis
Y N Hepatitis
Y N Radiation/Chemotherapy
Y N Mentally Challenged/Autistic/CP
Y N Nervous Problems/Psychiatric Care
Y N Major Surgery _________________
____

Y N Asthma
Y N Sleep Apnea
Allergic to:
Y N Aspirin
Y N Penicillin
Y N Codeine
Y N Novocaine
Y N Latex
Y N Other _____________________
____

If you marked **YES** to any of the answers above, please explain: ______________________________

How much/often do you smoke?__________________________

What hospitalizations have you had in the past 5 years? ______________________________

Any other medical information the doctor should be aware of? ______________________________

Dental Insurance

Will you be using dental insurance? ________

Name of Dental Insurance Company: ______________________________

Patient Consent

I hereby consent to the treatment requested by me, including but not limited to the taking of photographs and dental radiographs for diagnostic, promotional and educational purposes, and the use of local anesthetics, relaxant medicines, laughing gas or a combination as required for completing treatment rendered. I understand that perfect results cannot be guaranteed. I certify that all the above information is true and correct to the best of my information, knowledge and belief.

______________________________ ______________________________
Patient's Signature (Parent/Guardian) Date