Steven D. Cawley, DDS
1210 East Main Street
Mount Joy, PA 17552
717-928-2653

Patient Information

Patient Name_____
Last First Middle Initial
Address_____
Street City State Zip Code
Home Phone_____ Cell Phone_____ Work Phone_____
Birth Date_____ Social Security Number_____
E-mail address_____

If patient is a minor, Parent or Guardian Information

(Person responsible for account)

Name_____
Last First Middle Initial
Address (if different than Patient)_____
Street City State Zip Code
Home Phone_____ Cell Phone_____
Birth Date_____ Relationship to patient_____
Spouse's Name_____ Birth Date_____

Dental Insurance Information

Person carrying insurance _____ Birth Date_____
Social Security Number_____ Employer's Name_____
Employer's Address_____
Street City State Zip Code
Name of Insurance Company_____ Group number_____
Insurance Identification Number_____

If dual coverage, secondary insurance Information:
Insurance Carrier's Name_____ Birth Date_____
Social Security Number_____ Employer's Name_____
Employer's Address_____
Street City State Zip Code
Name of Insurance Company_____ Group number_____
Insurance Identification Number_____

Emergency Contact Information

Name_____ Home Phone Number_____
Cell Phone Number_____ Work Number_____
Address_____
Street City State Zip Code

HIPPA Acknowledgement

Account Information may be released to:_____
Clinical Information may be released to:_____

The above information is accurate to the best of my knowledge. I have received a copy of Mount Joy Dental Associates privacy practices and authorize the release of information to the above listed people.

Signature:_____ Date_____

Health History

The following information is very important and will aid us in caring for your dental needs.

1. Do you have a Latex allergy?.....Yes No
2. Are you having pain or discomfort at this time? ……..……...…Yes No
3. Have you ever fainted in a dental office? .....Yes No
4. Do you smoke or chew tobacco? .....Yes No
5. Do you snore or use a CPAP machine?.....Yes No
6. Have you been under the care of a medical doctor during the past two years (other than routine)? ……Yes No
7. Name of your medical Physician_____
8. Please list any medications you are currently taking (including over the counter medications): _____
   _____
9. Please list medication allergies: _____
10. Please indicate which of the following you currently have or have had in the past ……

Heart Failure	Yes No	Cosmetic Surgery	Yes No	HIV Positive	Yes No
Heart Disease or Attack	Yes No	Emphysema	Yes No	Hepatitis	Yes No
Angina Pectoris	Yes No	Tuberculosis (TB)	Yes No	Type	
High Blood Pressure	Yes No	Asthma	Yes No	Liver Disease	Yes No
Mitral Valve Prolapse	Yes No	Sinus Trouble	Yes No	Yellow Jaundice	Yes No
Heart Murmur	Yes No	Allergies or Hives	Yes No	Blood Transfusion	Yes No
Rheumatic Fever	Yes No	Diabetes	Yes No	Alcohol or Drug Addiction	Yes No
Congenital Heart Lesions	Yes No	Thyroid Disease	Yes No	Hemophilia	Yes No
Scarlet Fever	Yes No	Radiation Therapy	Yes No	Cold Sores/Fever Blisters	Yes No
Artificial Heart Valve	Yes No	Chemotherapy	Yes No	Epilepsy or Seizures	Yes No
Heart Pacemaker	Yes No	Arthritis	Yes No	Fainting or Dizzy Spells	Yes No
Heart Surgery	Yes No	Rheumatism.	Yes No	Nervousness	Yes No
Artificial Joints (Hip,Knee,etc)	Yes No	Cortisone Medicine	Yes No	Depression	Yes No
Anemia	Yes No	Anticoagulant Medicine	Yes No	Psychiatric Treatment	Yes No
Stroke	Yes No	Glaucoma	Yes No	Sickle Cell Disease	Yes No
Kidney Trouble	Yes No	Pain in Jaw Joints	Yes No	Bruise Easily	Yes No
Ulcers	Yes No	A.I.D.S	Yes No	Allergies to Jewelry	Yes No

10. Do you bleed excessively when cut? .....Yes No
11. Is there any other condition or information concerning your health that we should know about?_____
    _____
    _____
12. Are you taking birth control pills? .....Yes No
13. Are you pregnant? .....Yes No
    If yes, what month? _____
14. Are you nursing? ……..……..…….Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I verify that the above information is true and correct to the best of my knowledge. I hereby authorize Mount Joy Dental Associates and their staff to perform for me and/or my dependents such dental treatment, medication or therapy as they deem appropriate and in connection therewith to take or prepare x-rays, models or other diagnostic aids. I acknowledge that the performance of dental services (especially the use of anesthetic) inherently involves some risk.

Our office utilizes certified licensed expanded function dental assistants, who may place amalgam and/or composite restorations.

Signature_____Date_____
Patient (Parent or Guardian, if patient is a minor)

Relationship to patient_____

Health History Reviewed by_____