



Fadi Karam DDS PLLC
 2131 Northampton Street
 Easton, PA 18042

PATIENT'S HISTORY AND INFORMATION

(Mr. Mrs. Ms. Dr.)
 Name _____ Nickname _____ Date of Birth _____ Age _____
 Address Street _____ City _____ Zip _____
 Soc. Security Number _____ Referred By _____
 Telephone (Home) _____ (Cell) _____ (Email) _____
 Employed by _____ Occupation _____ Phone _____
 Emergency Contact _____ Phone _____
 Person financially responsible _____ Address _____ Phone _____

Dental Insurance Information:

Primary _____	Secondary _____
Subscriber _____	Subscriber _____
Birthdate _____	Birthdate _____
Soc. Sec. No. _____	Soc. Sec. No. _____
Employers _____	Employer _____
Group No. _____	Group No. _____

MEDICAL HISTORY

Family Physician _____ Office Phone _____ Last Exam _____

Are you under any medical treatment now? _____

Have you had any major operations? If so, what? _____

Have you ever had a serious accident involving head injuries? _____

Have you ever had a blood transfusion? _____

Has a physician ever informed you that you had:

	Yes	No		Yes	No		Yes	No
Heart Ailment	_____	_____	AIDS, HIV	_____	_____	Any Intestinal Disease	_____	_____
Pacemaker	_____	_____	Artificial Joint	_____	_____	Any Venereal Disease	_____	_____
Artificial Heart Valve	_____	_____	Rheumatism or Arthritis	_____	_____	Yellow Jaundice or Hepatitis	_____	_____
High Blood Pressure	_____	_____	Tumor, Growths or Cancer	_____	_____	Diabetes	_____	_____
Heart Murmur	_____	_____	Any Blood Disease	_____	_____	Asthma	_____	_____
Rheumatic Fever	_____	_____	Any Liver Disease	_____	_____	Bleeding Disorder	_____	_____
Thyroid Disease	_____	_____	Any Kidney Disease	_____	_____	Nervous Disorder	_____	_____
Respiratory Disease	_____	_____	Any Stomach Disease	_____	_____			

What drugs or medication are you taking? _____

Are you in general good health at this time? _____

Have any wounds healed slowly or presented other complications? _____

Do you have a history of fainting? _____

Have you ever had any RADIATION TREATMENTS? _____

Women: Are you pregnant? _____ If yes, due date _____

ALLERGIES

Are you allergic to or have you had a reaction to: (to all **YES** responses, specify type of reaction - check DK if you do not know the answer):

	Yes	No	DK		Yes	No	DK
Local anesthetics _____	_____	_____	_____	Latex (rubber) _____	_____	_____	_____
Aspirin _____	_____	_____	_____	Iodine _____	_____	_____	_____
Penicillin or other antibiotics _____	_____	_____	_____	Hayfever / seasonal _____	_____	_____	_____
Barbiturates, sedatives, or sleeping pills _____	_____	_____	_____	Animals _____	_____	_____	_____
Sulfa drugs _____	_____	_____	_____	Food _____	_____	_____	_____
Codeine or other narcotics _____	_____	_____	_____	Other _____	_____	_____	_____
Metals _____	_____	_____	_____				

Please complete other side →

DENTAL HISTORY

Date of last dental visit _____ Date of last full mouth x-rays _____

Have you had previous bad dental experience? ____ if yes please explain: _____

Have you ever had any of the following:

MOUTH		Yes	No		Yes	No	TEETH		Yes	No
Bleeding, sore gums	_____	_____		Swelling, lumps in mouth	_____	_____	Loose teeth	_____	_____	
Unpleasant taste/bad breath	_____	_____		Ortho treatments (braces)	_____	_____	Sensitive to hot/cold sweets	_____	_____	
Burning tongue/lips	_____	_____		Clicking, popping jaw/ difficult opening/closing	_____	_____	Sensitive to biting/change in bite	_____	_____	
Frequent blister, lip/mouth	_____	_____					Clenching/grinding	_____	_____	

Reason for today's visit _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or medication, I will inform the dentist at the next appointment.

Signature of Patient, Parent or Guardian _____ Date _____

Signature of Doctor _____ Date _____

Have there been any changes in your health since your last dental visit?

Date _____ Doctor's Signature _____ Patient Signature _____

Date _____ Doctor's Signature _____ Patient Signature _____

Date _____ Doctor's Signature _____ Patient Signature _____

Date _____ Doctor's Signature _____ Patient Signature _____

Date _____ Doctor's Signature _____ Patient Signature _____

Date _____ Doctor's Signature _____ Patient Signature _____

Date _____ Doctor's Signature _____ Patient Signature _____

Date _____ Doctor's Signature _____ Patient Signature _____