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 _____ Social Security #: _____ - _____ - _____
Birth Date: _____ Age: _____ ☐Male ☐Female
Address: _____
City/State: _____ Zip: _____
Best Contact Phone #: _____
Employer:_____ Occupation:_____
☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Spouse Name: _____ Spouse Phone #: _____
Emergency Contact: _____ Emergency Contact Phone #: _____
Referred by: _____

PAYMENT/INSURANCE INFORMATION

Dental Insurance Carrier: _____
Insurance Claims Address: _____
Name of Subscriber: _____
Name of Employer: _____
Subscriber Birth Date: _____ Subscriber ID/SSN: _____
Person Responsible for Payments on the Account: _____

MEDICAL HISTORY

Now or in the past has the patient had:

☐Heart Problems	☐Diabetes	☐General Allergies
☐High Blood Pressure	☐Respiratory Disease	☐Arthritis
☐Low Blood Pressure	☐Back Problems	☐Sinus Problems
☐Circulatory Problems	☐Epilepsy/Fainting Spells/Seizures	☐AIDS/HIV
☐Nervous System Problems	☐Headaches	☐Psychiatric Care
☐Cancer/Tumor	☐Hepatitis/Jaundice/Liver Disease	☐Stroke
☐Radiation/Chemotherapy	☐Chronic Diarrhea	☐Ulcer
☐Artificial Heart Valves/Joints	☐Allergies to Medicine	☐Hemophilia
☐Thyroid Problems	☐Smoke/Chew Tobacco	☐Latex Allergy
☐Anesthesia Allergy	☐Metal Allergy	☐Metal Allergy

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

Have you ever responded adversely to any medical or dental treatment? If Yes, please explain:

_____

_____

Are you taking any medication currently? If Yes, please list: _____

_____

Women: Do you suspect you're pregnant? _____

Is there anything else we should know about your medical history? _____

_____

MEDICAL CONTACT INFORMATION

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

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:_____

MaryBeth Marcincin, D.M.D., M.S.
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: _____