Chappaqua Dentistry

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PATIENT INFORMATION

Welcome to our office!
The information provided is important to your dental health.

Patient's name_____ Preferred name_____ Birthdate_____

If minor, parent's names_____ ❍ Single ❍ Married ❍ Long Term Partner ❍ Divorced ❍ Widowed

Email_____ Home #_____ Cell #_____ Work #_____

Mailing address_____City_____ State_____ ZIP_____

Employer_____ Occupation_____

Spouse's name_____ Spouse's employer_____

Whom may we thank for referring you to our office? _____

BILLING, CREDIT AND INSURANCE INFORMATION: ❍ Not covered by insurance Your SSN_____

Dental insurance co._____ Group #_____

Covered by spouse's insurance? ❍ Yes ❍ No Spouse's dental insurance co._____ Group #_____

Spouse's birthdate_____Spouse's SSN_____

DENTAL HISTORY

Chief oral complaint_____

Date of last dental exam_____Any previous major dental treatment?_____

❍ Teeth sensitive to cold, heat, sweets or pressure
❍ Bleeding gums. How long?_____
❍ Food impaction
❍ Clenching or grinding
❍ Burning of tongue
❍ Swelling or lumps in mouth
❍ Frequent blisters on lips or mouth
❍ Pain around ear
❍ Unusual sounds in ear while eating
❍ Bad breath
❍ Unpleasant taste
❍ Unfavorable dental experience
❍ Complications from extraction
❍ Periodontal treatment
❍ Orthodontic treatment
❍ Mouth breathing
❍ Oral habits: nail biting, cheek biting, etc.
❍ Texture of toothbrush? _____
❍ Frequency of brushing? _____
❍ Dental floss
❍ Water jet device
❍ Disclosing tablets or solution
❍ Flouride supplements
❍ Alcohol
Do you smoke? ❍ Yes ❍ No
Do you use chewing tobacco? ❍ Yes ❍ No
❍ Other _____

MEDICAL HEALTH HISTORY

Physician's name_____ Date of last physical exam_____ Age _____

❍ Allergies to drugs
_____
_____
❍ Allergies to anesthetics
❍ Any heart ailments
❍ High blood pressure
❍ Neurological problems
❍ Radiation treatments
❍ Excessive bleeding from cut or extraction
❍ Anemia or blood problems
❍ Arthritis
❍ Chronic Fatigue Syndrome
❍ Asthma
❍ Hay fever or allergies in general
❍ Diabetes
❍ Kidney problems
❍ Latex sensitivity
❍ Liver problems or hepatitis
❍ Malignancies
❍ Psychiatric care/emotional problems
❍ Rheumatic fever
❍ Sinus problems
❍ Immune system disorder (AIDS, HIV)
❍ Stroke
❍ Thyroid
❍ Eye
❍ Tonsilitis
❍ Tuberculosis
❍ Ulcer or colitis
❍ Pregnancy? If yes, what month?_____
❍ Venereal disease
❍ Other_____

Describe any current medical treatment including drugs taken, even though not listed above:_____

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointments without a 24 hour notification. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are responsible for payments/fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all of our fees. Each fee is individual for the individual patient.

Signature of patient (or parent) _____ Date_____