Welcome

Chester Family Dental Care

Personal Information:

Name: ____ Date: ____________________

Address: ____

City: ________________________________ State: ______________________ Zip Code:______________

Phone Number: Home ____________________ Work: ___________________ Cell:______________________

Birthdate ____/____/_______ Social Security: _____-____-______ Gender: ___Male ___ Female

Status: ___Married ___Single ___Divorced ___Widowed ___Separated

Emergency Contact:______________________________ Phone number:______________________

Insurance

Do you have any dental insurance? ___ Yes ___No If so, please provide insurance card.
Employer Name:____

Medical History:

Primary Physician name: ________________________________ Phone #:___________________________

Are you currently being treated by a physician? ___ Yes ___No
If yes, please explain. ____
____

Have you been hospitalized? ___ Yes ___ No
If yes, please explain.
____
____

Have you had any major operations? ___ Yes ___ No
If so, please list operations: ____
Any artificial joints? ___ Yes ___ No If yes, please explain ______________________________________
Do you need any pre-med? ___ Yes ___ No If yes, what have you taken? __________________________
Are you taking any medications, pills, or drugs? ___ Yes ___ No
Please list any medications. (Prescription or over the counter)
____
____

Are you allergic to or have any reactions to the following (circle):

Y N Latex
Y N Codeine
Y N Iodine
Y N Penicillin
Y N Aspirin
Y N Metal allergy
Y N Sulfa drugs
Y N Barbiturates
Y N Sedatives

Any other allergies____

Do you have or have you had any of the following (circle):

Y N Bleeding Problems
Y N Anemia
Y N Abnormal Bleeding
Y N Hemophilia
Y N Convulsions/Epilepsy
Y N Cancer/Tumor
Y N Psychiatric Problems
Y N Diabetes: type I or II?
Y N HIV/Aids
Y N Substance Abuse
Y N Radiation/Chemotherapy
Y N Emphysema
Y N COPD
Y N Hepatitis
Y N Leukemia
Y N Asthma
Y N Tuberculosis
Y N Joint Replacement
Y N Fainting/Seizures/Epilepsy
Y N Stomach Problems/Ulcers
Y N Low/High Blood Pressure
Y N Heart Surgery
Y N Heart Attack/Stroke
Y N Heart Murmur
Y N Artificial Heart Valve
Y N Heart Disease
Y N Mitral Valve Prolapse
Y N Congenital Heart Defect
Y N Chest Pains
Y N Pacemaker
Y N Blood Thinner
Y N Thyroid/Kidney/Liver Problems

Do you use tobacco (including smokeless)? ___ Yes ___ No
Females: Are you pregnant? ___ Yes ___ No If yes, when is due date? _______________

Dental Health

Are you experiencing any of the following?

Y N Bleeding gums while brushing
Y N Tooth sensitivity to hot/cold
Y N Pain in any of your teeth
Y N Sores or lumps in or near the mouth
Y N Head, neck, or jaw injuries
Y N Interested in whitening your teeth
Y N Clenching or grinding of teeth
Y N Difficulty with past extractions
Y N Any orthodontic treatment
Y N Unhappy with the way your teeth look
Y N Periodontal Disease

Authorization and Release: I hereby authorize the dentist or designated staff to perform diagnostic procedures and treatment mutually agreed upon by me as may be required for proper dental care. I authorize release of any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or dentist. I attest to the accuracy of the information on this form and understand that this examination will address my immediate problem and confirm this is not a complete examination and/or treatment. To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the dental office of any changes in my medical status.

____ __________________
Responsible party's signature Date