WELCOME

TO CHESTER FAMILY DENTAL CARE, LLC

Today's Date ___________________ File #__________

Patient Name:__________________________________
Last First

What do you prefer to be called?_______________

Birthdate:____/____/_______

SS# _____-______-_________

Mailing Address: _______________________________

____

City State Zip Code

Home Phone #:_____________________________

Work Phone #: _____________________________

Cell Phone #:_______________________________

Email Address:_____________________________

Employer:_________________________________

Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name:_____________________________

Do you have children? ☐ Yes ☐ No How many?___

Referred by: _______________________________

ALLERGIES

____

____

____

Insurance Information

Primary Dental Insurance Company

Insurance Name:_______________________

Address:_____________________________

____

City State Zip Code

Phone #:________________________

Insured SS#:_____-______-________

Insured Name:__________________

Relation:_________________

Date of Birth:____/____/_______

Insured's Employer:__________________

Secondary Dental Insurance

Insurance Name:_______________________

Address: ____________________________

____

City State Zip Code

Phone #:_______________________

Insured SS#:_____-_____-________

Insured Name:__________________

Relation:________________

Date of Birth:____/____/______

Insured's Employer:__________________

Account Information

Person to be responsible for account.

Name:____

Relation: ___________________________

Billing Address: _____________________________________

____

City State Zip Code

SS# :______-______-________

Home Phone #:______________________

I here authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. ***I understand that in the event my account becomes delinquent I will be responsible for any collections, attorney's fees, court costs or interest (and any other charges incurred to collect this account) on the principal balance of 18% (eighteen) per annum from the date of service.________ (initials)***

In Case of Emergency

Whom should we contact?

____

Relation:______________________________

Home Phone #:_________________________

Work Phone #:_________________________

Cell Phone #:__________________________

Who is your medical doctor?______________________________

Adult Dental Information

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation

Are you in pain: ☐ Yes ☐ No If yes, how long?______________________

Please indicate any of the following problems:

☐ Discomfort, clicking or popping in jaw ☐ Lost/Broken filling
☐ Stained teeth ☐ Teeth grinding
☐ Red, swollen or bleeding gums ☐ Locking jaw
☐ Sensitive teeth, tooth, or gums ☐ Ringing in the ears
☐ Blisters/sores in or around the mouth ☐ Bad Breath
☐ Broken/chipped tooth ☐ Other__________________

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know

Previous Dentist?________________________Phone #:________________

Last Dental Exam:___/___/_____ Last Dental X-rays ___/___/_____

Times per day you brush?________ Times a week you floss?____________

What type of tooth brush do you use: ☐ Soft ☐ Medium ☐ Hard

How would you rate your smile? (best) 1 2345678910 (worst)

Adult Medical History

Are you taking any of the following medications? ☐ Nerve Pills ☐ Pain killer (including aspirin)

☐ Muscle relaxers ☐ Stimulants ☐ Blood thinners ☐ Tranquilizers ☐ Insulin

☐ Other(s), please list:____

Do you have or have had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/Stroke	**Y N** Thyroid Problems	**Y N** Cancer/Tumors	**Y N** Cosmetic Surgery
Y N Heart Surg./Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** X-ray/ Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV+/AID/RC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/Rheumatism	**Y N** Difficulty Breathing
Y N Artificial Valves	**Y N** Stomach Problems/Ulcer	**Y N** Artificial Bones/Joints	**Y N** Diabetes/ Hypoglycemia
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Emphysema	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/Seizures/ Epilepsy	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/Drug Problem	**Y N** Severe/Frequent Headaches	**Y N** High/Low Blood Pressure
Y N Scarlet Fever	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Problems TMJ/TMD	**Y N** Back Problems	**Y N** Glaucoma

Please list any other surgeries or medical conditions you have or ever had_____________________________________

____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Aspirin

☐ Dental Anesthetics ☐ Other:_________________________________

Do you use tobacco? ☐ No ☐ Yes/Which product?______________ How much?___________ How long?__________

Do you wear contact lenses? ☐ Yes ☐ No Have you ever taken the drug Phen-fen or Redux? ☐ Yes ☐ No

For women only: Are you taking Birth Control? ☐ Yes ☐ No Are you pregnant? ☐ No ☐ Yes /Due date?_______

Are you nursing? ☐ Yes ☐ No

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform of any changes to the information I have provided.

Signature____________________________________ Date____/____/________