Chester Family Dentistry

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Home Phone _____ Cell Phone _____ Text Messaging ☐ Yes ☐ No

Work Phone _____ Email _____

Employer _____ Occupation _____

Whom may we thank for referring you? _____

In case of emergency please notify _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Primary Insurance

Policy Holder _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____ Birthdate _____
(If different from patient)

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Text Messaging ☐ Yes ☐ No Email _____

Employer _____ Relation to Patient _____

Insurance Company _____ Insurance Phone _____

Group/Policy # _____ Subscriber/ID # _____

Secondary Insurance

Policy Holder _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____ Birthdate _____
(If different from patient)

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Text Messaging ☐ Yes ☐ No Email _____

Employer _____ Relation to Patient _____

Insurance Company _____ Insurance Phone _____

Group/Policy # _____ Subscriber/ID # _____

Dental Information

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation Are you in dental discomfort today? _____

Please indicate if you have/had problems with the following:

☐Y ☐N Bad Breath ☐Y ☐N Food collection between teeth ☐Y ☐N Periodontal Treatment ☐Y ☐N Sensitivity to sweets

☐Y ☐N Bleeding gums ☐Y ☐N Grinding or clenching teeth ☐Y ☐N Sensitivity to cold ☐Y ☐N Sensitivity when biting

☐Y ☐N Loose teeth ☐Y ☐N Sores/Blister in or around mouth ☐Y ☐N Broken/Chipped teeth ☐Y ☐N Clicking/popping jaw

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Yes ☐ No

Former Dentist _____ Phone Number _____

Address _____

Date of last dental care _____ Date of last x-rays _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physicians name _____ Phone _____

Have you ever been hospitalized or had a major operation? Please list _____

Are you taking any medications, pills, or drugs? Please list _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates or IV Bisphosphonates? ☐ Yes ☐ No _____

Women: Are You: Pregnant/Trying to get pregnant? ☐ Yes ☐ No _____ Taking Oral Contraceptives ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Do you use tobacco? ☐ No ☐ Yes/How used? _____ How much _____ How long_____

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other : Please explain _____

Do you have, or have you had any of the following?

AIDS/HIV Positive	☐Y ☐N	Cortisone Medication	☐Y ☐N	Hemophilia	☐Y ☐N	Radiation Treatment	☐Y ☐N
Alzheimer's Disease	☐Y ☐N	Diabetes	☐Y ☐N	Hepatitis A	☐Y ☐N	Recent Weight Loss	☐Y ☐N
Anaphylaxis	☐Y ☐N	Drug Addiction	☐Y ☐N	Hepatitis B or C	☐Y ☐N	Renal Dialysis	☐Y ☐N
Anemia	☐Y ☐N	Easily Winded	☐Y ☐N	Herpes	☐Y ☐N	Rheumatic Fever	☐Y ☐N
Angina	☐Y ☐N	Emphysema	☐Y ☐N	High Blood Pressure	☐Y ☐N	Rheumatism	☐Y ☐N
Arthritis/Gout	☐Y ☐N	Epilepsy or Seizures	☐Y ☐N	High Cholesterol	☐Y ☐N	Shingles	☐Y ☐N
Artificial Heart Valves	☐Y ☐N	Excessive Bleeding	☐Y ☐N	Hives or Rash	☐Y ☐N	Scarlet Fever	☐Y ☐N
Artificial Joints	☐Y ☐N	Excessive Thirst	☐Y ☐N	Hypoglycemia	☐Y ☐N	Sickle Cell Disease	☐Y ☐N
Asthma	☐Y ☐N	Fainting Spells/Dizziness	☐Y ☐N	Irregular Heartbeat	☐Y ☐N	Sinus Trouble	☐Y ☐N
Blood Disease	☐Y ☐N	Frequent Cough	☐Y ☐N	Kidney Problems	☐Y ☐N	Spina Bifida	☐Y ☐N
Blood Transfusion	☐Y ☐N	Frequent Diarrhea	☐Y ☐N	Leukemia	☐Y ☐N	Stomach/Intestinal Disease	☐Y ☐N
Breathing Problem	☐Y ☐N	Frequent Headaches	☐Y ☐N	Liver Disease	☐Y ☐N	Stroke	☐Y ☐N
Bruise Easily	☐Y ☐N	Genital Herpes	☐Y ☐N	Low Blood Pressure	☐Y ☐N	Swelling of Limbs	☐Y ☐N
Cancer	☐Y ☐N	Glaucoma	☐Y ☐N	Lung Disease	☐Y ☐N	Thyroid Disease	☐Y ☐N
Chemotherapy	☐Y ☐N	Hay Fever	☐Y ☐N	Mitral Valve Prolapse	☐Y ☐N	Tonsilitis	☐Y ☐N
Chest Pain	☐Y ☐N	Heart Attack/Failure	☐Y ☐N	Osteoporosis	☐Y ☐N	Tuberculosis	☐Y ☐N
Cold Sores/Fever Blisters	☐Y ☐N	Heart Murmur	☐Y ☐N	Pain in Jaw Joints	☐Y ☐N	Tumors or Growths	☐Y ☐N
Congenital Heart Disorder	☐Y ☐N	Heart Pacemaker	☐Y ☐N	Parathyroid Disease	☐Y ☐N	Ulcer	☐Y ☐N
Convulsions	☐Y ☐N	Heart Trouble/Disease	☐Y ☐N	Psychiatric Care	☐Y ☐N	Venereal Disease	☐Y ☐N
						Yellow Jaundice	☐Y ☐N

Comments: _____

- To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medial status.
- 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.
- 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. It is my responsibility to inform the office of any changes in the information I have provided.

SIGNATURE _____ Date _____

☐ Adult Patient ☐ Parent or Legal Guardian ☐ Spouse