Danville Family Dentist
Dental Practice of Shailaja Singh DDS

To meet all your healthcare needs, please fill out this form completely and accurately.

Patient Information (CONFIDENTIAL) Date: _____

Name: _____ Birthdate: _____ SS#: _____
Cell Phone: _____ **Email address**: _____
Address: _____ City:_____ State: _____ Zip: _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed
If Student, Name of School/ College_____ City_____ State____ ☐ Full time ☐ Part time
Patient or Parent/Guardian's Employer_____ WorkPhone_____
Business Address_____ City_____ State_____ Zip/P.C._____
Spouse or Parent/Guardian's Name_____ Employer_____ Work Phone_____
Whom may we thank for referring you: _____
Person to contact in case of emergency: _____ Relation: _____

Responsible Party (If filling out for child-complete this section)

Name of Person Responsible for this Account_____ Relationship to Patient_____
Address_____ Home Phone_____
Email_____ Cell Phone_____
Driver's License #_____ Birthdate _____ Financial Institution_____
Employer_____ Work Phone_____ SS#/SIN_____
Is this Person Currently a Patient in our office? ☐ YES ☐ NO
It is customary to pay in full for services rendered. Check the payment option you prefer.
☐ Cash ☐ Check ☐ Visa ☐ MasterCard ☐ AMEX ☐ Care Credit ☐ Flex Spending Account

Insurance Information

Name of Insured_____ Relationship to Patient_____
Birthdate_____ SS#/SIN_____
Name of Employer_____ Work Phone_____
Address of Employer_____ City_____ State_____ Zip/P.C._____
Insurance Company_____ Group #_____ Policy/ ID#_____
Ins. Co. Address_____ City_____ State_____ Zip/P.C._____

Do You Have Any Additional Insurance? ☐ Yes ☐ No

Name of Insured_____ Relationship to Patient_____
Birthdate_____ SS#/SIN_____
Name of Employer_____ Work Phone_____
Address of Employer_____ City_____ State_____ Zip/P.C._____
Insurance Company_____ Group #_____ Policy/ ID#_____
Ins. Co. Address_____ City_____ State_____ Zip/P.C._____

Patient Dental History

Name of Previous Dentist and Location_____ Date of Last Exam_____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet/sour foods?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficulty with extractions in the past?	☐	☐
12. Have you ever had prolonged bleeding following extractions?	☐	☐
13. Have you ever had orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth or gums?	☐	☐
Do you like your smile?	☐	☐

Patient Medical History

Physician name: _____Office Phone: _____Date of Last Exam: _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you been hospitalized for any surgical operation or serious illness with the last 5 years? If yes please explain_____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____ _____		
4. Have you ever taken Fen-Phen/ Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐
8. Women Only:		
a. Are you pregnant or think you may be pregnant?	☐	☐
b. Are you nursing?	☐	☐
c. Are you taking oral contraceptives?	☐	☐

	Yes	No
9. Are you allergic to or have you had any reactions to the following?		
➢Local Anesthetics (e.g. Novocain)	☐	☐
➢Penicillin or any other Antibiotics	☐	☐
➢Sulfa Drugs	☐	☐
➢Barbiturates	☐	☐
➢Sedatives	☐	☐
➢Iodine	☐	☐
➢Aspirin	☐	☐
➢Any Metals (e.g. Nickel, Mercury, etc.)	☐	☐
➢Latex Rubber	☐	☐
➢Other (please list) _____ _____		
10. Do you have a persistent cough or throat cleaning not associated with a known illness (lasting more than 3 weeks?)	☐	☐

11. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsion	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____		

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such Dental care to third party payer's and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient (Parent/guardian if minor)

Doctor's Comments _____

_____

Signature_____ Date _____