Cheshire Dental Associates

Patient Name_____ **Patient Soc. Sec #**_____

Spouse Name_____ **Spouse Soc. Sec #**_____

Address_____ **Date of Birth**_____

City, State, Zip_____ **Home Phone**_____

Cell Phone_____ **Work Phone**_____

Email_____ **Referred By**_____

How should we contact you?

Email ___ Cell Phone___ Home Phone___ Work Phone___

Your Primary Insurance Company Name		**Effective Date**
Primary Insurance Company's Address		**Phone**
City	**State**	**Zip**
Policy Holder's ID number		Group Plan Number
Employer's Name		
Your Secondary Insurance Company's Name		Effective Date
Primary Insurance Company's Address		Phone
City	State	Zip
Policy Holder's ID Number		Group Plan Number
Employer's Name		
Name of Insured		Date of Birth

Financial Policy

1. Payment is expected at the time the work is done. Although you may have insurance, your "Patient Portion" must be paid at the time of visit.
2. Financial agreements must be made if payment in full at each visit is not possible. Finance charge of 1.5% (18% annually) will be added monthly after 60 days to any unpaid balance. In the event of default, the patient and/or guardian are liable for all collection costs and reasonable attorney fees.
3. We accept Cash, Check, Credit Cards and Care Credit

_____

(Signature of Patient and/or Guardian)

Dental and Oral Health Information

Patient's name: _____ **Date:** _____

Please describe any specific dental problem or discomfort you are having at this time:_____

_____ How long has it been present? _____

If you have had any of the following dental care please list the dentists and approximate dates:

Periodontal (**g**um) **t**reatment or **s**urgery _____

"Braces" or **a**ny **t**ype of **o**rthodontic **t**reatment: _____

Dental **i**mplants:_____

Any **o**ther **t**ype of **o**ral **s**urgery: _____

Do **y**ou **h**ave **/ have you h**ad **/ have you noticed a**ny of the **f**ollowing **s**igns or **s**ymptoms in **y**our **head, neck,** or **m**outh?

(Please **c**heck Yes or No for **e**ach **q**uestion)	Yes	No		Yes	No
Teeth that are sensitive to:			A clicking, snapping or difficulty when chewing	___	___
Hot, cold, sweets, or biting pressure	___	___	Difficulty opening or moving the jaws	___	___
An unpleasant taste or persistent bad breath	___	___	Difficulty speaking or changes in your voice	___	___
Does food catch between your teeth	___	___	Difficulty moving your tongue or "tongue tied"	___	___
Do your gums bleed when brushing	___	___	Loose or separating teeth	___	___
Red, swollen, tender, bleeding, or sore gums	___	___	Changes in the way your teeth fit together	___	___
Gums that have pulled away from the teeth	___	___	A color change of the tissues in your mouth	___	___
Pus between the teeth and gums	___	___	Pain, tenderness, numbness, or earaches	___	___
Avoid any area when brushing or chewing	___	___	Any lumps, swelling or swollen glands	___	___
You clench or grind your teeth	___	___	Sores, ulcers, or rough spots in your mouth	___	___

Your Dental Health:

How **d**o **y**ou **r**ate **y**our **o**verall **d**ental **h**ealth? £ Good £ Fair £ Poor

How **m**any **t**imes a **d**ay **d**o **y**ou **b**rush **y**our **t**eeth? _____ How **m**any **t**imes a **w**eek **d**o **y**ou **f**loss **y**our **t**eeth? _____

Do **y**ou **u**se **a**ny of the **f**ollowing? (Please **c**heck Yes or No for **e**ach **q**uestion) Yes No

- Mechanical (electric) toothbrush If Yes, what type or brand? _____ ___ ___
- Flossing aids (floss holders, threaders, etc.) ___ ___
- Oral irrigating device (Waterpik) ___ ___
- Fluoride treatments or supplements at home. If Yes, which ones: _____ ___ ___
- Mouthwashes or oral rinses. If Yes, what brand? _____ ___ ___

Do **y**ou **h**ave **a**ny **m**issing **t**eeth **t**hat **h**ave **n**ot **b**een **r**eplaced? ___ ___
Why have you not had them replaced? _____

Do **y**ou **w**ear **a**ny **r**emovable **d**ental **a**ppliances? ___ ___
If Yes, what type and for how long? _____

Have **y**ou **e**ver **h**ad **y**our **t**eeth **w**hitened or **b**leached? ___ ___
Would you like to have your teeth whitened or bleached? ___ ___

How **d**o **y**ou **f**eel **a**bout the **a**ppearance of **y**our **s**mile and **w**hat **w**ould **y**ou **c**hange **i**f **y**ou **c**ould?
_____

Are **y**ou **c**oncerned **a**bout the **f**inances **r**equired to **r**eturn **y**our **m**outh to **e**xcellent **h**ealth? ___ ___

Are **y**ou **f**rustrated **b**ecause **y**ou **a**lways **n**eed **s**omething **t**reated or **r**epaired **w**hen **y**ou **v**isit a **d**entist? ___ ___

Do **y**ou **f**eel **y**ou **w**ill **e**ventually **w**ear **a**rtificial **d**entures? ___ ___

Have **y**ou **e**ver **h**ad **a**ny **c**omplications **f**rom **a**n **e**xtraction or **d**ental **t**reatment? ___ ___
If Yes, please explain: _____

Have **y**ou **e**ver **h**ad **a**ny **o**ther **d**ental **c**onditions, **m**ajor **t**rauma or **i**njury to **y**our **h**ead, **n**eck, or **m**outh**?** ___ ___
If Yes, please specify: _____

If **y**ou are a **n**ew **p**atient to this **p**ractice:
Date of last dental visit_____ Dentist's name _____City & State_____

 Reviewed By: _____

Health Information and History

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

If you are completing this form for another person:

Your name: _____ Phone: _____ Relationship: _____

Emergency Contact: (If not listed above)

Name: _____ Phone: _____ Relationship: _____

Primary Physician: _____ Phone: _____ City & State: _____

Date of last physical examination: _____ Date of last blood test/work up: _____

Other Physicians & Specialists

Name: _____ Specialty: _____ Phone: _____ City & State: _____

Name: _____ Specialty: _____ Phone: _____ City & State: _____

1. With in the last 3 years, have you been hospitalized or had surgery? ☐ Yes ☐ No

If Yes, please give reasons and dates: _____

2. Have you ever been instructed to take ANY medications or take ANY special precautions before any dental appointments*? ☐ Yes ☐ No

If Yes, please explain: _____

3. Are you taking ANY drugs, medications, or treatments at this time? ☐ Yes ☐ No

(If you brought a complete written list with you, give that to the receptionist instead)

Prescribed: _____

_____

Over-the-counter (OTC) medications (such as Aspirin, Advil, allergy medication, sleeping aids, etc):

_____

Vitamins, natural or herbal preparations and/or dietary supplements:

_____

Are you having or have you ever had radiation or chemotherapy treatments*? ☐ Yes ☐ No

If Yes, for how long?_____ Name of facility performing the treatment :_____

4. Are you taking or have you ever taken / been treated with a Bisphosphonate (Fosamax)? ☐ Yes ☐ No

5. Are you allergic to or have you ever experienced an unusual reaction to:

___Latex ___Metals or jewelry ___Dental anesthesia (local)

___Fluoride ___Nitrous oxide (laughing gas) ___General anesthesia

6. Are you allergic to or have you ever had any reaction to any of the following drugs?

___Penicillin (or related drugs) ___Tranquilizers (Valium) ___Tetra cycline ___Codeine

___Aspirin / Ibuprofen (Advil, Motrin, Nuprin) ___ Keflex (Cephalexin) ___Sulfa drugs ___Iodine

___NSAID (Celebrex, Vioxx, Anaprox) ___ Clindamycin (Cleocin) ___Erythromycin

7. Have you had an allergic reaction or unusual response to ANY other medications, drugs, pills, or treatments? ☐ Yes ☐ No

If Yes, please list :_____

Continued on next page…

Reviewed By: _____

Health Information and History (continued)

Patient's Name: _____

8. Do you have, or have you ever had, any of the following? (Please check Yes or No for each question)

	Yes	No
Congenital heart defects	___	___
Angina or chest pains	___	___
Atherosclerosis	___	___
Congestive heart failure	___	___
Coronary artery disease	___	___
Heart surgery If Yes, type & date _____	___	___
Heart attack If Yes, date _____	___	___
Rheumatic heart disease / rheumatic fever	___	___
Infective Endocarditis*	___	___
Heart valve(s) damage / Mitral valve prolapse	___	___
Artificial heart valve	___	___
Pacemaker	___	___
Stroke or CVA	___	___
High blood pressure	___	___
Low blood pressure	___	___
Anemia	___	___
Hemophilia or bleeding disorder	___	___
Excessive bleeding from any cut or incident	___	___
Diabetes or blood sugar problems	___	___
Any artificial joint, joint surgery, or prosthesis If Yes, what join t or area: _____ When was operation done: _____	___	___
Hepatitis, jaundice, or other liver problems	___	___
Any form of cancer	___	___
An organ transplant	___	___

	Yes	No
Asthma	___	___
Hay fever, skin or food allergies or allergies in general	___	___
Sinus problems	___	___
Tuberculosis, emphysema or lung disorder	___	___
Skin problems	___	___
A sore or wound that bleeds easily or does not heal	___	___
A thyroid problem or disease	___	___
Arthritis	___	___
Glaucoma or any eye diseases	___	___
Epilepsy or other seizure disorder	___	___
Any kidney problems	___	___
Ulcers, acid reflux, or stomach problems	___	___
A compromised immune system (Lupus, HIV, AIDS, radiation immune problem, etc.)	___	___
An active sexually transmitted disease (STD)	___	___
Any mental health issues	___	___
Been treated for any psychiatric condition	___	___

Women Only:	Yes	No
Are you pregnant If Yes, what is your due date: _____	___	___
Do you think you might be pregnant	___	___
Are you presently nursing	___	___
Are you using birth control medication	___	___
Are you taking hormone replacement therapy	___	___

9. Do you have any other conditions, diseases, or medical problems, or is there ANY other information that you would like us to know about, or that we should be made aware of? ☐ Yes ☐ No

If Yes, please explain: _____

_____

_____

_____

CONSENT — To the best of my knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice.

I understand there are no guarantees or warranties in health or dental care.

Signature_____ Date _____

(Parent or guardian, if patient is a minor)

Reviewed By: _____

CHESHIRE DENTAL ASSOCIATES, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

MISSED APPOINTMENTS

Any missed appointment that was not cancelled with CDA personnel, at least 24 hours in advance, a $25.00 fee will be charged to your account. Subsequent missed appointments will be subject to additional fees.

_____ _____

Signature **Date**