

Cheshire Dental Associates

18+ patients

Patient Name _____ Date of Birth _____

Soc Sec # _____ DL # & State _____ Referred By _____

Spouse Name _____ Phone _____ Spouse Soc Sec # _____

Emergency Contact (if not above) _____ Phone _____ Relationship _____

Address _____

City, State, Zip _____

Cell Phone _____ Home Phone _____

Other Phone _____ Email _____

Preferred pharmacy & location _____

How should we contact you? Cell Phone _____ Home Phone _____ Other Phone _____ Email _____

Cheshire Dental Associate bills may be sent electronically via ___ text/email or ___ paper statement via mail. Please indicate preferred method.

Cheshire Dental Associate appointments may be confirmed electronically via text/email through our system. You may opt out of our electronic confirmation system and you will receive phone calls to confirm at the number given. Thank you.

Your Primary Insurance Company Name		Effective Date
Primary Insurance Company's Address		Phone
City	State	Zip
Name of Insured		Date of Birth
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		

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 parent/guardian are liable for all collection costs and reasonable attorney fees.
3. We accept Cash, Check, Credit Cards, Care Credit.

Signature of Patient _____

Date _____

Cheshire Dental Associates, P.C.

CONSENT

To the best of my knowledge, all of the given 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 treatment. I also hereby consent to allow diagnosis, proper healthcare 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 _____

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.

Signature _____ Date _____

Print Name _____

MISSED APPOINTMENTS & LATE ARRIVAL POLICIES

Cheshire Dental Associates strives to appoint our patients in such a manner as to maximize our service potential. We also allow time to ensure your dental needs are met with as minor an impact on your busy schedule as possible. It is appropriate if you need to cancel an appointment to give us a 24-hour notice as we may contact a patient who is on our waiting list to better serve their needs.

For 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.

If you are going to be more than 5 minutes late to your appointment, please call our office to update staff on your arrival time. Cheshire Dental Associates has the right to reschedule any appointment due to excessive tardiness.

Signature _____ Date _____

Reviewed by _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:

YES NO

YES NO

1. hospitalization for illness or injury _____
2. an allergic or bad reaction to any of the following:
aspirin, ibuprofen, acetaminophen, codeine _____
penicillin _____
erythromycin _____
tetracycline _____
sulfa _____
local anesthetic _____
fluoride _____
chlorhexidine (CHX) _____
iodine _____
metals (nickel, gold, silver, _____)
latex _____
nuts _____
fruit _____
milk _____
red dye _____
other _____
3. heart problems, or cardiac stent within the last six months _____
4. history of infective endocarditis _____
5. artificial heart valve, repaired heart defect (PFO) _____
6. pacemaker or implantable defibrillator _____
7. orthopedic or soft tissue implant (e.g joint replacement, breast implant) _____
8. heart murmur, rheumatic or scarlet fever _____
9. high or low blood pressure _____
10. a stroke (taking blood thinners) _____
11. anemia or other blood disorder _____
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____
14. chronic ear infections, tuberculosis, measles, chicken pox _____
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____
17. kidney disease _____
18. liver disease or jaundice _____
19. vertigo (e.g. "the room is spinning") _____
20. thyroid, parathyroid disease, or calcium deficiency _____
21. hormone deficiency or imbalance (e.g. polycystic ovarian syndrome) _____
22. high cholesterol or taking statin drugs _____
23. diabetes (HbA1c = _____) _____
24. stomach or duodenal ulcer _____
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____

26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____
27. arthritis or gout _____
28. autoimmune disease
(e.g. rheumatoid arthritis, lupus, scleroderma) _____
29. glaucoma _____
30. contact lenses _____
31. head or neck injuries _____
32. epilepsy, convulsions (seizures) _____
33. neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease) _____
34. viral infections and cold sores _____
35. any lumps or swelling in the mouth _____
36. hives, skin rash, hay fever _____
37. STI/STD/HPV _____
38. hepatitis (type _____) _____
39. HIV/AIDS _____
40. tumor, abnormal growth _____
41. radiation therapy _____
42. chemotherapy, immunosuppressive medication _____
43. emotional difficulties _____
44. psychiatric treatment or antidepressant medication _____
45. concentration problems or ADD/ADHD _____
46. alcohol/recreational drug use _____

ARE YOU:

47. presently being treated for any other illness _____
48. aware of a change in your health in the last 24 hours
(e.g., fever, chills, new cough, or diarrhea) _____
49. taking medication for weight management _____
50. taking dietary supplements, vitamins, and/or probiotics _____
51. often exhausted or fatigued _____
52. experiencing frequent headaches or chronic pain _____
53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____
54. considered a touchy/sensitive person _____
55. often unhappy or depressed _____
56. taking birth control pills _____
57. currently pregnant _____
58. diagnosed with a prostate disorder _____

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Signature _____ Date _____



DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____
Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam ____ / ____ / ____ Date of most recent x-rays ____ / ____ / ____
Date of most recent treatment (other than a cleaning) ____ / ____ / ____
I routinely see my dentist every 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

   YES NO

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____
2. Have you had an unfavorable dental experience? _____
3. Have you ever had complications from past dental treatment? _____
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____

GUM AND BONE

   YES NO

7. Do your gums bleed sometimes or are they ever painful when brushing or flossing? _____
8. Have you ever had or been told you have gum disease, gum or bone loss between your teeth, or had scaling and root planing? _____
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____
10. Is there anyone with a history of periodontal disease in your family? _____
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? _____
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____

TOOTH STRUCTURE

   YES NO

14. Have you had any cavities within the past 3 years? _____
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____
18. Do you have grooves or notches on your teeth near the gum line? _____
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____
20. Do you frequently get food caught between any teeth? _____

BITE AND JAW JOINT

   YES NO

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____
25. Are your teeth becoming more crooked, crowded, or overlapped? _____
26. Are your teeth developing spaces or becoming more loose? _____
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? _____
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____
30. Do you clench or grind your teeth together in the daytime or make them sore? _____
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? _____
32. Do you wear or have you ever worn a bite appliance? _____

SMILE CHARACTERISTICS

   YES NO

33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)? _____
34. Have you ever bleached (whitened) your teeth? _____
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____
36. Have you been disappointed with the appearance of previous dental work? _____

Patient's Signature _____ Date _____

Provider's Signature _____ Date _____