CHITTENANGO
FAMILY DENTAL

Welcome....
to our practice!

Name:_____ I prefer to be called:_____ D.O.B:_____ Age:_____

Male [ ] Female [ ] SS#:_____ Email:_____ Single [ ] Married [ ] Other [ ]

Home address:_____

Home#:( )_____ Cell#:( )_____ Work#:( )_____

Employer:_____Occupation:_____ How long there?:_____

Employer Address:_____ Where/Best time to reach you?:_____

Whom may we thank for referring you?_____ Other Family seen by us?_____

Previous Dentist?:_____ Date of last dental exam?:_____

Spouse Information: Spouse Name:_____ D.O.B:_____ Employer:_____

Emergency Contact- Name:_____ Relationship:_____ Phone#: ( )_____

Who is responsible for this account?:_____

Dental Insurance Name:_____ ID#:_____ Insurance Address:_____

Ins Company Phone#:( )_____ Group#:_____Whom carries this Dental Plan?_____

If not listed above: Insured's Name:_____Relationship:_____D.O.B:_____

What Pharmacy do you use?:_____**Pharmacy Phone #:**_____

Address:_____

Do you have a personal physician? **Yes** **No** Are you currently under the care of a physician? **Yes** **No**

Physicians Name:_____ Phone Number:_____ Location:_____

Payment is due in full at the time of visit unless prior arrangements have been approved. This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

Signature: _____Date:_____

MEDICAL HISTORY: (Please Circle Answers)

Why have you come to the dentist today?_____

Your current Physical Health is? **Good** **Fair** **Poor**

Do you smoke or use tobacco? **Yes** **No** If Yes do you use a vape? **Yes** **No**

Have you had surgery in the last 5 years? **Yes** **No** Explain:_____

Have you had any metal rods, pins or implants? **Yes** **No** Explain:_____

Have you been hospitalized in the last 5 years? **Yes** **No** Explain:_____

Have you ever taken Fosamax, or any other bisphosphonate (typically prescribed for osteoporosis)? **Yes** **No**

Do you or your family have a history of cancer? **Yes** **No** Explain:_____

Do you or your family have a history of heart disease? **Yes** **No** Explain:_____

DENTAL HISTORY: Are you currently in pain? **Yes** **No** Your current dental health is **Good** [ ] **Fair** [ ] **Poor** [ ]

Do you require antibiotics before dental treatment? **Yes** **No**

Do you floss daily? **Yes** **No**

Have you ever had gum treatment? **Yes** **No**

Have you ever had periodontal disease? **Yes** **No**

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/TMD)? **Yes** **No**

Are your teeth sensitive to heat, cold or anything else? Please List _____

Do you have loose teeth? **Yes** **No**

Do you still have wisdom teeth? **Yes** **No**

Would you like fresher breath? **Yes** **No**

Would you like a whiter smile? **Yes** **No**

Are you happy with the way your smile looks? **Yes** **No** If not what would you change?_____

FOR WOMEN: Are you using a prescribed method of birth control? **Yes** **No**

Are you pregnant? **Yes** **No** Weeks#:_____ Are you nursing? **Yes** **No**

SLEEP HEALTH: Do you feel tired throughout the day? **YES** **NO** Explain: _____

Do you wish you slept better and had more energy? **YES** **NO** Explain: _____

Have you ever been told you occasionally snore? **YES** **NO** Explain: _____

Have you or a loved one been prescribed a CPAP? **YES** **NO** Explain: _____

Have you ever had any of the following? Please check □

□ Abnormal bleeding
□ AIDS/HIV
□ ADD/ADHD
□ Anemia
□ Arthritis
□ Artificial joints
□ Asthma
□ Blood disease
□ Blood transfusion
□ Cancer
□ Chemotherapy
□ Cold Sores
□ Colitis
□ Congenital heart defect
□ Dementia
□ Diabetes
□ Dialysis
□ Difficulty breathing
□ Dizziness
□ Emphysema
□ Epilepsy
□ Fainting
□ Frequent headaches
□ Glaucoma
□ Hay Fever
□ Head Injury
□ Heart Attack
□ Heart Disease
□ Heart Murmur
□ Heart Surgery
□ Heart Transplant
□ Hepatitis
□ Herpes
□ High Blood Pressure
□ Kidney Disease
□ Kidney Problems
□ Kidney Transplant
□ Liver disease
□ Liver transplant
□ Low Blood Pressure
□ Lupus
□ Mitral Valve Prolapse
□ Nervous Disorders
□ Pacemaker
□ Parkinson's
□ Psychiatric Treatment
□ Radiation Treatment
□ Rheumatic Fever
□ Scarlet Fever
□ Seizures
□ Shingles
□ Sinus Problems
□ Stomach Problems
□ Stroke
□ Stints/Shunts
□ Substance Abuse
□ TB
□ Thyroid Problems
□ Tumors
□ Ulcers
□ Venereal Disease

Are you allergic to any of the following? Please check □

□ Codeine
□ Dental Anesthetics
□ Erythromycin
□ Iodine
□ Latex
□ Penicillin
□ Sulfa
□ Tetracycline
□ Other:_____

Are you taking any prescriptions or over the counter drugs? YES NO

Please List:_____
_____
_____

I understand that the information I've given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature_____ Date:_____

HIPAA Acknowledgement

I understand that I have been offered or given a copy of the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. This office reserves the right to supply personal health information for treatment, payment, and healthcare operations.

I allow the following named person/people to have knowledge of my dental treatment or dental needs:

Named person: _____ Relationship: _____

Signature:_____ Date:_____