Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us, we will be happy to help.

Patient Information:

Name:_____Date:_____

Check appropriate line: ___Minor ___Single ___Married ___Divorced ___Widowed Sex:____M _____F

Birthdate:_____Social Security Number:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Cell Phone:_____ Work:_____

E-Mail:_____

Occupation/Employer:_____ _____

Name and phone number of Emergency Contact:_____

How did you hear about our office? _____

Responsible Party:

Name of person responsible for this account:_____

Birthdate:_____Social Security Number:_____

Address:_____

Home Phone:_____Cell Phone:_____ Work:_____

Insurance Information: (Please provide Dental Insurance Card and Driver's License for the receptionist)

Insurance Company:_____

Name of Insured:_____

Employer:_____Group number:_____

ID or Social Security number:_____Birthdate:_____

I understand I am financially responsible for charges not covered by insurance at the time of service. I also agree to be responsible for payment during any ineligible period. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. I understand that collection and attorney fees may be added to any accounts not paid in 90 days. Finally, I confirm that I am not currently filing for or in bankruptcy.

Signature of responsible party:_____Date:_____

Health History

Patient name:_____**Date:**_____

In the past two years, have you been under the care of a physician or hospitalized? Yes No

If yes, for what:_____

Name of Family Physician:_____**Phone**:_____

What medications including non-prescription medication are you currently taking?

_____

Please circle any of the following that apply to you:

Addiction	Diabetes	High Blood Pressure	Radiation (Head/Neck)
AIDS	Dizziness	HIV	Recreational Drug Use
Alcohol Abuse	CPAP Use	Human Papillomavirus	Respiratory Problems
Allergies (Seasonal)	Drug Addiction	Jaundice	Rheumatism
Anemia	Emphysema	Kidney Disease	Rheumatic Fever
Angina (Chest Pains)	Epilepsy/Seizures	Liver Disease	Sinus Problems
Arthritis	Excessive Bleeding	Low Blood Pressure	Sleep Apnea
Artificial Heart Valve	Fainting	Marijuana Use	Stomach Problems
Artificial Joints	Glaucoma	Metastatic Cancer	Stroke
Asthma	Hay Fever	Nervous Disorders	Swollen Ankles
Blood Disease	Head Injuries	Osteopenia	Thyroid Problems
Cancer/Chemotherapy	Heart Attack	Osteoporosis	Tuberculosis
Chronic Fatigue	Heart Disease	Pacemaker	Tumors
Cortisone Medication	Hepatitis	Pregnant (Currently)	Ulcers

Other: _____

Are you allergic or have you reacted adversely to any of the following? Yes No

If yes, please circle all that apply or add if not listed:

Aspirin Amoxicillin Clindamycin Codeine Erythromycin Ibuprofen Latex

Local Anesthetic Nickel Nitrous Oxide Penicillin Sulfa Tetracycline Tylenol Valium

Other: _____

Have you ever taken any of the following bone medications? Yes No

Actonel Aredia Avasti Boniva Denosumab Fosamax Palmidronate

Prolia Reclast Sutent Xgeva Zoledroniate Zometa

The above information is true to the best of my knowledge. I do hereby authorize Chesterton Family Dental to use diagnostic aides like x-rays and photos, to administer anesthetics and to perform dental treatment as needed for the above named person.

Signed:_____**Date:**_____

Dental History

Are you having any specific problems with your teeth or gums? Yes No

If yes, please explain:_____

Are your teeth sensitive to hot, cold, pressure or sweets? Yes No

If yes, where?_____

Do you have any loose, broken, tipped or shifting teeth? Yes No

Do you have difficulty swallowing or chewing? Yes No

Do you frequently wedge food between your teeth? Yes No

Do your gums bleed or get sore/irritated after brushing or flossing? Yes No

Do you have fever blisters, mouth ulcers or sores on your lips or in your mouth? Yes No

Do you have chapped, cracked or raw corners on your lips? Yes No

Do you snore or have others noticed you snoring? Yes No

Do you clench or grind your teeth during the day or at night? Yes No

Do you experience headaches, ear aches or neck pain? Yes No

Do you notice popping, clicking or soreness of the jaw? Yes No

Have you worn braces for straightening your teeth? Yes No

Are you dissatisfied with the appearance of your teeth and smile? Yes No

If yes, please circle all that apply below:

Make it whiter Make it straighter Close spaces

Replace black metal fillings with tooth colored restorations Have a smile makeover

Repair chipped teeth Replace missing teeth Replace old crowns that don't match

Does dental treatment cause you much concern or worry? Yes No

If yes, please explain:_____

Do you chew or smoke tobacco in any form? Yes No

If yes, how much per day and for how long?_____

Name of Previous Dentist:_____

When was your last dental checkup/cleaning? _____

When were x-rays of your teeth last taken? _____

Why did you leave your previous dental office? _____

What is the most important thing to you about your smile and dental health?_____

Signed:_____Date:_____

Chesterton Family Dental

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****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}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I,_____ , authorize the following person(s) to have access to

information covered under the Privacy Practice regarding myself.

_____	_____
{Please Print Name}	Relationship
_____	_____
{Please Print Name}	Relationship
_____	_____
{Please Print Name}	Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify)

_____

Adult Sleep Screening Questionnaire

Please answer the questions below to help us assess the possibility of a sleep disorder which may be related to you dental and overall health. There is often a correlation between grinding of teeth, TMJ disorders, breakdown of the teeth and sleep disorders. Sleep apnea may also increase your risk for many different health conditions including heart attack and stroke.

Name:_____ Height:_____ Weight:_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze
1 = I have a slight chance of dozing
2 = I have a moderate chance of dozing
3 = I have a high chance of dozing

Situation	**Chance of Dozing**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car while stopped for a few minutes in traffic	_____
Total Score	_____

Have you ever been diagnosed with:

Impaired Cognition (i.e. difficulty concentrating or thinking)	Yes	No
Mood Disorders/Depression	Yes	No
Insomnia	Yes	No
Hypertension (high blood pressure)	Yes	No
Ischemic Heart Disease (Coronary Artery Disease/Atherosclerosis)	Yes	No
History of Stroke	Yes	No
Sleep Apnea	Yes	No
If yes: Did you try to use CPAP	Yes	No
TMJ problems significant enough to require treatment	Yes	No
Gastric Reflux (GERD) or Heartburn	Yes	No

Are you aware of (or have you been told):

Snoring on a regular basis	Yes	No
Feeling tired or fatigued on a regular basis	Yes	No
Clenching or grinding your teeth (bruxism)	Yes	No
Having frequent headaches	Yes	No
Your neck size being > 17 inches (male) or > 16 inches (female)	Yes	No
Anyone in your family having sleep apnea	Yes	No
Stopping breathing when sleeping/awakening with a gasp	Yes	No

Child Sleep Screening Questionnaire

To be filled out by parent or guardian.

Are you aware of your child:

Snoring/noisy breathing while sleeping	Yes	No
Grinding his or her teeth	Yes	No
Wetting the bed	Yes	No
Having difficulty in school/learning	Yes	No
Being treated for ADD or ADHD	Yes	No
Breathing primarily through their mouth	Yes	No
Having frequent nightmares/night terrors	Yes	No
Having frequent ear aches	Yes	No

Esthetic Evaluation

If you are completely satisfied with the appearance of your teeth and smile, there is no need to fill out this form.

Name:_____ Date:_____

To aid in our diagnosis and treatment of your esthetics concerns, please take a moment and answer the following questions. Please circle your answer.

Do you dislike the color of your teeth?	Yes	No
Do you have spaces between your teeth that bother you?	Yes	No
Do you have chips or uneven edges on your teeth?	Yes	No
Do you feel your teeth are too long or too short?	Yes	No
Do you have dark fillings that show when you smile?	Yes	No
Do your gums show too much when you smile?	Yes	No
Are your teeth too crowded or crooked?	Yes	No
Do you have existing crown or dental work that you consider “ugly”?	Yes	No
Are you self-conscious of your teeth and/or smile?	Yes	No
Has anyone suggested you should do something about your teeth/smile?	Yes	No
Do you avoid smiling when you have your picture taken?	Yes	No
Would you like to improve your existing smile?	Yes	No
Do you wish you had a “new smile”?	Yes	No

What concerns do you have regarding dental treatment to improve your smile?

Fear of treatment	Time of treatment concerns	Financial concerns	Distance to office
Embarrassment	Understanding treatment	Other:_____	

COVID-19 PANDEMIC-PATIENT DISCLOSURE

Our ultimate goal is your health. In order to keep you and our team safe, it is important that you disclose any indication of having been exposed to or having experienced any signs/symptoms associated with the Covid-19 virus prior to your visit today. Also, please be advised that a weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at a greater risk for contracting COVID-19. Our staff are symptom-free and to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge. Please disclose to us any conditions that potentially compromise your immune system.

- Are you currently or have you recently experienced a fever?
  Yes No
- Are you currently or have you recently experienced shortness of breath?
  Yes No
- Are you currently or have you recently experienced a cough?
  Yes No
- Are you currently experiencing a reduction in or loss of taste/smell?
  Yes No
- Are you currently or have you recently experienced any other flu like symptoms?
  Yes No
- Have you been in contact with someone who has tested positive for COVID-19?
  Yes No
- Have you tested for COVID-19 and either tested positive or awaiting results?
  Yes No
- Have you traveled internationally within the last 21 days?
  Yes No
- Have you traveled domestically within the last 21 days
  Yes No

I fully understand and acknowledge that there is some risk of contracting viruses, including COVID-19, while having dental treatment done. Also, I understand the risks and cautions regarding a compromised immune system and have disclosed to my provider all my current and previous conditions in my health history.

By signing this document, I acknowledge that the answers I have provided are true and accurate.

PRINT NAME: _____Date:_____

Signature: _____