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:_____

Preferred contact method (please circle): Phone Text Email

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:_____

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 clench or grind your teeth? 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:**_____

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:

AIDS	Diabetes	Hepatitis	Respiratory Problems
Allergies (seasonal)	Dizziness	High Blood Pressure	Rheumatic Fever
Anemia	Drug Addiction	HIV	Rheumatism
Angina (chest pains)	Emphysema	Human Papiloma Virus	Sinus Problems
Arthritis	Epilepsy/Seizures	Jaundice	Sleep Apnea
Artificial Heart Valve	Excessive Bleeding	Kidney Disease	Stomach Problems
Artificial Joints	Fainting	Liver Disease	Stroke
Asthma	Glaucoma	Low Blood Pressure	Swollen Ankles
Blood Disease	Hay Fever	Nervous Disorders	Thyroid Problems
Cancer/Chemotherapy	Head Injuries	Pacemaker	Tuberculosis
Chronic Fatigue	Heart Attack	Pregnant (currently)	Tumors
Cortisone Medication	Heart Disease	Radiation (head/neck)	Ulcers
Metastatic Cancer	Osteoporosis	Osteopenia	

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	Erthromycin	Ibuprofen	Latex
Local Anesthetic	Nitrous Oxide	Penicillin	Sulfa	Tetracycline	Tylenol	Valium

Other:_____

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

Actonel	Aredia	Boniva	Fosamax	Reclast	Zometa
Avastin	Sutent	Xgeva	Prolia	Denosumab	Zoledroniate
Palmidronate					

The above information is true to the best of my knowledge. I do hereby authorize Chesterton/Schererville Family Dentistry 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:**_____