CHESTER SPRINGS DENTAL

PATIENT INFORMATION FORM

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PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST, FIRST, MIDDLE) ❒ MR. ❒ MRS. ❒ MISS	DATE OF BIRTH / /	AGE	MARITAL STATUS ❒ S ❒ M	TODAY'S DATE / /
ADDRESS (STREET, CITY, STATE, ZIP)	HOME PHONE ( )			
NAME OF EMPLOYER	OCCUPATION	WORK PHONE ( )	EXTENSION	
EMPLOYER ADDRESS (STREET, CITY, STATE, ZIP)	SOCIAL SECURITY NO.			
SPOUSE'S NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH / /	NAME OF EMPLOYER	WORK PHONE ( )	
NEAREST FRIEND NOT LIVING WITH YOU	PHONE NO. ( )	NEAREST RELATIVE NOT LIVING WITH YOU	PHONE NO. ( )	
IN CASE OF EMERGENCY CONTACT NAME:	RELATIONSHIP	PHONE NO. ( )		
WHO MAY WE THANK FOR REFERRING YOU TO US?	FAMILY PHYSICIAN	PHONE NO. ( )	FAMILY DENTIST	PHONE NO. ( )
WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?	I WILL BE PAYING TODAY BY ❒ CASH ❒ CHECK ❒ CREDIT CARD			

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET, CITY, STATE, ZIP)		PHONE NO. ( )
NAME OF INSURED	RELATIONSHIP	I. D. NO.	GROUP NO.
SECONDARY INSURANCE NAME	ADDRESS (STREET, CITY, STATE, ZIP)		PHONE NO. ( )
NAME OF INSURED	RELATIONSHIP	I. D. NO.	GROUP NO.

PAYMENT POLICY

Payment for routine care is expected at time of service. At this time, we will submit your insurance for you. Reimbursement for covered benefits will be paid directly to you. For more extensive treatment, financial arrangements will be made with the business office.

Please feel free to discuss financial arrangements or billing matters with our office at any time.

CHESTER SPRINGS DENTAL

MED. HX

Name: _____ Date: _____

Do you have any dental condition which you believe requires immediate attention today? Please describe: _____

_____

How long have you noticed this problem? _____

YES NO **MEDICAL HISTORY**

1. Have you been treated by a physician or stayed overnight in the hospital in the past year? If so, describe: _____
   _____
2. Has there been any change in your general health in the past year?
   Approximate the date of your last physical examination: _____
3. Are you being treated for any condition by a physician now? If so, what? _____
4. List all the medications or drugs you are taking at the present time.

Medications	**Dosage**

5. Are you allergic to penicillin?
6. Has anyone ever told you not to take a particular drug (aspirin, Novocaine, codeine, sulfa, ect.)?
7. Have you ever had jaundice or hepatitis?
8. Have you ever had TB (tuberculosis) or lived with anyone who had TB?
9. Have you ever been told you had any of the following: *(please check all that apply)*

☐ Rheumatic Fever	☐ High or Low Blood Pressure	☐ Psychological Problems
☐ Heart Murmur	☐ Diabetes	☐ Any Kind of Blood Disorder or Bleeding Problems
☐ Heart Attack or Coronary	☐ Kidney Disease	
☐ Angina	☐ Epilepsy or Seizures	

YES NO

10. Have you ever had any sexually transmitted diseases, HIV or HIV related illnesses?
11. Has anyone in your immediate family ever had any of the following? *(please check all that apply)*

☐ High Blood Pressure	☐ Heart Problems
☐ Diabetes	☐ Bleeding or Blood Disorder

FOR WOMEN

12. Are you now pregnant or think you are pregnant?

DENTAL HISTORY

1. Have you ever had a complete series of x-rays taken of your teeth? If so, when was the last time? _____
2. Have you often had severe toothaches?
3. Have you ever had treatment for your gums?
4. Are you satisfied with the appearance of your teeth?
5. Do your gums bleed or hurt when you brush them?
6. Have you been aware of any bad odor or taste in your mouth?
7. Are you teeth sensitive to heat, cold, or sweets?
8. Do any teeth hurt when you chew?
9. Have your teeth moved or drifted from their normal position?
10. Do you clamp, clench, or grind your teeth during the day or night?
11. Have you ever had troublesome pain in your jaw joint?
12. Is there any health information which was not asked, which you feel may influence dental treatment?
    If so, what? _____
    _____
13. What is the main reason you are here? _____
    _____

Date		Date		Date		Date		Date		Date	
BP	Pulse	BP	Pulse	BP	Pulse	BP	Pulse	BP	Pulse	BP	Pulse

ORAL EXAMINATIONS

N	AB		N	AB		N	AB		N	AB	
☐	☐	Lips	☐	☐	Palatine Pillars	☐	☐	Hard Palate	☐	☐	Aveolar Ridges-Maxilla
☐	☐	Buccal Mucosa	☐	☐	Tonsils	☐	☐	Soft Palate	☐	☐	Aveolar Ridges-Mandible
☐	☐	Tongue	☐	☐	Posterior Pharyngeal Wall	☐	☐	Temporomandibular Joint	☐	☐	Bony Tissues
☐	☐	Floor of Mouth	☐	☐	Gingiva						
☐	☐										

DESCRIBE ANY ABNORMALITY OR POSITIVE FINDINGS