PATIENT INFORMATION

Date_____

Name_____

SS#_____

Address_____
City_____ State_____Zip_____
Home Phone (____)_____Work Phone (_____)_____
Cell Phone (____)_____
e-mail_____
Sex M_____ F____ Age_____ Birthdate_____
Married ___ Widowed ___ Single ___ Separated ___ Divorced ___
Partnered for____Years

Occupation_____
Patient Employer/School _____
Employer/School Address_____
Employer/School Phone (_____)_____

Spouse's Name_____ Birthdate_____
SS#_____
Spouse's Employer_____

Who may we thank for referring you?
_____

EMERGENCY CONTACT

Name_____
Relationship_____
Home Phone_____
Work Phone_____

DENTAL INSURANCE INFORMATION

Who is responsible for this account?_____
Relationship to patient_____
SS# _____ Birthdate _____
Insurance company _____
Group # _____
Address_____
Phone (____)_____

Is patient covered under additional insurance? Yes___ No___
Subscriber's Name_____
Relationship to patient_____
SS# _____ Birthdate_____
Insurance company _____
Group #_____
Address _____
Phone (____)_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____(Name of Insurance company) and assign directly to Westchester Dental Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentists may use my heath care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

Please print name of Patient, Parent, Guardian or Personal Representative

_____

Relationship to Patient _____

DENTAL HISTORY

Reason for today's visit_____

Former Dentist_____
City/State_____
Date of last dental visit_____
Date of last x-rays_____

Place mark on "Yes" or "No" to indicate if you have had any of the following:

Bad breath	Yes___	No___
Bleeding gums	Yes___	No___
Blisters on lips or mouth	Yes___	No___
Burning sensation on tongue	Yes___	No___
Chew on one side of mouth	Yes___	No___
Cigarette, pipe or cigar smoking	Yes___	No___
Clicking or popping jaw	Yes___	No___
Dry mouth	Yes___	No___
Fingernail biting	Yes___	No___
Food collection between teeth	Yes___	No___
Foreign objects	Yes___	No___
Grinding teeth	Yes___	No___
Gums swollen or tender	Yes___	No___
Jaw pain or tiredness	Yes___	No___
Lip or cheek biting	Yes___	No___
Loose teeth or broken fillings	Yes___	No___
Mouth breathing	Yes___	No___
Mouth pain, brushing	Yes___	No___
Orthodontic treatment	Yes___	No___
Pain around ear	Yes___	No___
Periodontal treatment	Yes___	No___
Sensitivity to cold	Yes___	No___
Sensitivity to heat	Yes___	No___
Sensitivity to sweets	Yes___	No___
Sensitivity when biting	Yes___	No___
Sores or growths in your mouth	Yes___	No___

How often do you floss?_____
How often do you brush?_____

HEALTH HISTORY

Physician's Name_____
Date of last visit_____

ALLERGIES

- ❑ Aspirin
- ❑ Barbiturates (sleeping pills)
- ❑ Codeine
- ❑ Iodine
- ❑ Latex
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sulfa
- ❑ Other_____

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____
_____

Do you wear contact lenses?	Yes__ _No___
Women: Are you pregnant?	Yes___ No___
Are you nursing?	Yes___ No___
Taking birth control Pills?	Yes___ No___

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes___ No___	Swollen Neck Glands	Yes___ No___
Anemia	Yes___ No___	Thyroid Problems	Yes___ No___
Arthritis, Rheumatism	Yes___ No___	Tonsillitis	Yes___ No___
Artificial Heart Valves	Yes___ No___	Tuberculosis	Yes__ _ No___
Artificial Joints	Yes___ No___	Tumor/Growth on head/neck	Yes___ No___
Asthma	Yes___ No___	Ulcer	Yes___ No___
Back Problems	Yes___ No___	Venereal Disease	Yes___ No___
Bleeding abnormal with extractions or surgery	Yes___ No___	Weight Loss, unexplained	Yes___ No___
Blood Disease	Yes___ No___		
Cancer	Yes___ No___		
Chemical Dependency	Yes___ No___		
Chemotherapy	Yes___ No___		
Circulatory Problems	Yes___ No___		
Congenital Heart Lesions	Yes___ No___		
Cortisone Treatments	Yes___ No___		
Cough, persistent or bloody	Yes___ No___		
Diabetes	Yes___ No___		
Emphysema	Yes___ No___		
Epilepsy	Yes___ No___		
Fainting or dizziness	Yes___ No___		
Glaucoma	Yes___ No___		
Headaches	Yes___ No___		
Heart Problems	Yes___ No___		
Hepatitis Type_____	Yes___ No___		
Herpes	Yes___ No___		
High Blood Pressure	Yes___ No___		
Jaundice	Yes___ No___		
Kidney Disease	Yes___ No___		
Liver Disease	Yes___ No___		
Low Blood Pressure	Yes___ No___		
Mitral Valve Prolapse	Yes___ No___		
Nervous Problems	Yes___ No___		
Psychiatric Care	Yes___ No___		
Radiation Treatment	Yes___ No___		
Respiratory Disease	Yes___ No___		
Rheumatic or Scarlet Fever	Yes___ No___		
Shortness of Breath	Yes___ No___		
Sinus Trouble	Yes___ No___		
Skin Rash	Yes___ No___		
Special Diet	Yes___ No___		
Stroke	Yes___ No___		
Swollen Feet or Ankles	Yes___ No___		