Chatham
Dental Associates
P.A.
973-635-5522

www.chatham-dental.com

Adult

Welcome to our office. We appreciate the confidence you place with us to provide your dental care. To assist us in serving you, please complete the following forms. The information provided on this form is important to your dental health. If you have any questions please do not hesitate to ask. Please fill out the forms and print. Please fax to 973-635-6910, mail or bring your completed forms with you. Please do not email the forms back.

PATIENT INFORMATION . . .

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name_____M.I. _____ Last Name _____Nickname_____

Sex: ❑ Male ❑ Female Birth Date_____ Soc. Sec. # _____E-mail_____

Street_____Apt. _____City_____ State _____ Zip _____

Cell (_____)_____ Home (_____)_____

Employer _____ Work (_____) _____

Please indicate preferred method of contact. E-mail_____ Text _____ Cell_____Home_____Work _____Mail _____ **(Number in order of preference)**

Referred By _____

Previous Dentist_____ Medical Doctor _____

In case of emergency, please contact _____ Tel. (_____) _____ Relation_____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT . . .

❑ Self (If self, skip this section) ❑ Spouse ❑ Other_____

First Name_____ Last Name_____ Soc. Sec. # _____ Birth Date _____

Tel. (_____)_____

Street_____Apt. _____City_____ State _____ Zip _____

Employer _____ Work (_____) _____

Please provide a copy of your dental insurance card.

DENTAL INFORMATION . . .

What is your chief concern for your visit? _____

_____

Y ❑ N ❑ Are you satisfied with your past dentistry? If no, what were you not satisfied with. _____
How many times a day do you brush your teeth? ____/Floss?____

Y ❑ N ❑ Is your brush sensitive? _____ soft _____ medium _____ hard

Y ❑ N ❑ Do you use a Sonicare toothbrush?

Y ❑ N ❑ Do your gums bleed when you brush or floss?

Y ❑ N ❑ Are your teeth sensitive to hot, cold or sweets?
How long have you been experiencing pain or discomfort? _____
Please rate the pain a scale of 1-10 with
10 being the worst. _____

Y ❑ N ❑ Do you have any broken teeth or fillings?

Y ❑ N ❑ Have you had any periodontal (gum) surgery?

Y ❑ N ❑ Have you ever had any root canals?

Y ❑ N ❑ Is your home water supply fluoridated?

Y ❑ N ❑ Do you grind or clench your teeth?

Y ❑ N ❑ Have you noticed any wear on the edges of your teeth?

Y ❑ N ❑ Do you have any pain when opening or closing?

Y ❑ N ❑ Do you have any earaches or ringing in your ears?

Y ❑ N ❑ Do you have any neck pain or frequent headaches?

Y ❑ N ❑ Do you have clicking, popping or discomfort in your jaw?

Y ❑ N ❑ Has your jaw ever locked open or closed?

Y ❑ N ❑ Are you under excess stress?

Y ❑ N ❑ Do any of your teeth feel loose?

Y ❑ N ❑ Do you wear a night guard?

Y ❑ N ❑ Have you ever had your bite adjusted?

Y ❑ N ❑ Do you have frequent sores, ulcers in your mouth or cold sores on your lips?

Y ❑ N ❑ Do you wear dentures or partials?

Y ❑ N ❑ Have you had any tooth implants?

Y ❑ N ❑ Do you participate in any contact sports activities?

Y ❑ N ❑ Do you wear a mouth guard?

Y ❑ N ❑ Have you ever had a serious injury to your head, mouth or jaw?

Y ❑ N ❑ Have you had your wisdom teeth extracted?

Y ❑ N ❑ Have you ever had prolonged bleeding after an extraction?

Y ❑ N ❑ Does food get caught between your teeth?

Y ❑ N ❑ Do you have trouble with bad breath?

Y ❑ N ❑ Do you have any swelling or lumps in your mouth?

Y ❑ N ❑ Do you have sleep apnea?

Y ❑ N ❑ Have you ever done a sleep study for sleep apnea?

Y ❑ N ❑ Do you wear an appliance for sleep apnea or use a C-pap machine?

Y ❑ N ❑ Do you experience anxiety with dental treatment?

Y ❑ N ❑ Have you ever had a bad dental experience?

Y ❑ N ❑ Have you had orthodontic treatment?

Y ❑ N ❑ Do you still wear a retainer?

Y ❑ N ❑ Have you noticed any changes in your tooth positions?

Y ❑ N ❑ Would you like your teeth to be straighter?

Y ❑ N ❑ Have you ever bleached your teeth?

Y ❑ N ❑ Were you happy with the results?

Y ❑ N ❑ Would you like your teeth whiter?
Please rate your smile on a scale of 1-10.
(10 being the best) _____
Is there anything you would like to change about the appearance of your smile?_____

MEDICAL INFORMATION . . .

	Yes	No
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date:_____ If yes, have you had any complications?	☐	☐
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) intravenous bisphosphonates (Aredia or Zometa) for osteoporosis, Paget's disease or cancers?	☐	☐

List any medications you are taking.

_____

_____

	Yes	No
Do you use controlled substances (drugs)?	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)? If so, how interested are you in stopping? (Select one)☐ VERY ☐ SOMEWHAT ☐ NOT INTERESTED	☐	☐
Do you drink alcoholic beverages? If yes, how much do you typically drink in a week? _____	☐	☐
WOMEN ONLY Are you:		
Pregnant? Number of weeks: _____	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐
Nursing?	☐	☐

_____

_____

Allergies - Are you allergic to or have you had a reaction to: To all **yes** responses, specify type of reaction.	Yes	No
Local anesthetics_____	☐	☐
Aspirin _____	☐	☐
Penicillin or other antibiotics _____	☐	☐
Sulfa drugs_____	☐	☐
Codeine or other narcotics _____	☐	☐
Metals_____	☐	☐

	Yes	No
Latex (rubber)_____	☐	☐
Iodine _____	☐	☐
Hay fever/seasonal _____	☐	☐
Food_____	☐	☐
Other_____	☐	☐
Gluten_____	☐	☐

MEDICAL HISTORY

Y ❑ N ❑ Acid reflux/Gerds
Y ❑ N ❑ Aids/ HIV positive
Y ❑ N ❑ Alzheimer's disease
Y ❑ N ❑ Autoimmune disease
Y ❑ N ❑ Anaphylaxis
Y ❑ N ❑ Anemia/Sickle Cell/ Hemophilia
Y ❑ N ❑ Angina
Y ❑ N ❑ Arthritis/Gout
Y ❑ N ❑ Artificial heart valve
Y ❑ N ❑ Artificial joint
Y ❑ N ❑ Arteriosclerosis
Y ❑ N ❑ Asthma
Y ❑ N ❑ Blood disease
Y ❑ N ❑ Blood transfusion
Y ❑ N ❑ Breathing problem
Y ❑ N ❑ Bruise easily
Y ❑ N ❑ Cancer
Y ❑ N ❑ Celiac Disease
Y ❑ N ❑ Chemotherapy
Y ❑ N ❑ Chest pains/Easily winded
Y ❑ N ❑ Chronic fatigue syndrome
Y ❑ N ❑ Cold sores/ fever blisters
Y ❑ N ❑ Congenital heart disorders
Y ❑ N ❑ Convulsion
Y ❑ N ❑ Contagious disease
Y ❑ N ❑ Cortisone medicine
Y ❑ N ❑ Diabetes
Y ❑ N ❑ Drug addiction
Y ❑ N ❑ Eating disorders
Y ❑ N ❑ Emphysema/COPD
Y ❑ N ❑ Epilepsy/seizures
Y ❑ N ❑ Excessive bleeding
Y ❑ N ❑ Excessive thirst
Y ❑ N ❑ Fainting spells/dizziness
Y ❑ N ❑ Frequent cough
Y ❑ N ❑ Frequent headaches
Y ❑ N ❑ Glaucoma
Y ❑ N ❑ Heart attack/failure
Y ❑ N ❑ Heart murmur/ Irregular heartbeat
Y ❑ N ❑ Heart pacemaker
Y ❑ N ❑ Heart trouble/disease
Y ❑ N ❑ Hepatitis B/C
Y ❑ N ❑ Herpes
Y ❑ N ❑ High blood pressure
Y ❑ N ❑ Low blood pressure
Y ❑ N ❑ Hives/rash
Y ❑ N ❑ HPV
Y ❑ N ❑ Hyperglycemia
Y ❑ N ❑ Kidney problems
Y ❑ N ❑ Leukemia
Y ❑ N ❑ Liver disease
Y ❑ N ❑ Lupus
Y ❑ N ❑ Lymes disease
Y ❑ N ❑ Mitral valve prolapse
Y ❑ N ❑ Pain in jaw or joints
Y ❑ N ❑ Psychiatric care
Y ❑ N ❑ Radiation treatment
Y ❑ N ❑ Unexplained weight loss or gain
Y ❑ N ❑ Renal dialysis
Y ❑ N ❑ Rheumatic fever
Y ❑ N ❑ Rheumatism
Y ❑ N ❑ Scarlet fever
Y ❑ N ❑ Shingles
Y ❑ N ❑ Sinus trouble
Y ❑ N ❑ Stomach/intestinal disease
Y ❑ N ❑ Stroke
Y ❑ N ❑ Swelling of limbs
Y ❑ N ❑ Thyroid disease
Y ❑ N ❑ Tuberculosis
Y ❑ N ❑ Tumors
Y ❑ N ❑ Ulcers
Y ❑ N ❑ Venereal disease
Y ❑ N ❑ Vision or hearing impairments

Have you had any serious illness not listed above? If yes please explain: _____

To the best of my knowledge all of the preceding answers are true and correct. I understand that providing incorrect information can be dangerous. I ever have any change in my health or change in my medication I will inform the dentist, hygienist or the dental office.

_____/_____
Signature of patient or legal guardian Date

_____
Dentist signature/Date

_____
Relationship to patient

_____
Dental hygienist/ Date

Fees and payments:

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Arrangements can be made depending upon special circumstances. An estimate of the charge for any procedure will be given to you upon your request. If you have any dental insurance we will be glad to fill out the proper forms and submit the claim. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.

X_____ X_____
Signature of patient Date

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to the doctor named of the benefits otherwise payable to me.

X_____/_____
Signature of patient Date

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X_____/_____
Signature of patient Date