Chatham Prosthodontics

Committed to Excellence in the Art of Cosmetic, Implant, and Reconstructive Dentistry

# PATIENT INFORMATION AND HEALTH HISTORY

TODAY'S DATE_____

PATIENT NAME_____ DATE OF BIRTH_____

___SINGLE ___MARRIED ___PARTNER ___WIDOWED ___DIVORCED

ADDRESS_____HOME PHONE_____

CITY STATE ZIP

EMPLOYED BY_____WORK PHONE_____CELL PHONE_____

E-MAIL_____ WHO MAY WE THANK FOR THIS REFERRAL_____

EMERGENCY CONTACT_____ PHONE_____

## DENTAL HISTORY

CHIEF ORAL COMPLAINT_____

DATE OF LAST DENTAL EXAM_____ DATE OF LAST FULL SERIES X-RAYS_____

DO YOU HAVE OR USE ANY OF THE FOLLOWING?

- ☐ Alcohol / Recreational Drugs
- ☐ Anxiety about Dental Treatment
- ☐ Bad Breath / Unpleasant Taste
- ☐ Bleeding Gums, How Long?
- ☐ Burning Sensation on Tongue
- ☐ Chew on One Side of Mouth
- ☐ Cigarettes, Pipe, or Cigar Smoking
- ☐ Clenching or Grinding
- ☐ Complications from Extractions
- ☐ Dental Floss
- ☐ Difficulty Getting Numb
- ☐ Dry Mouth
- ☐ Ear Ache, Ringing in Ears
- ☐ Fluoride Supplements
- ☐ Food Packing Between Teeth
- ☐ Frequent Blisters on Lips or Mouth
- ☐ Hearing Loss
- ☐ Oral Habits, Such as Fingernail or Cheek Biting
- ☐ Orthodontic Treatment
- ☐ Pain Around Ear
- ☐ Periodontal Treatment
- ☐ Swelling, Tenderness, or Lumps in Mouth
- ☐ Teeth Sensitive to Cold
- ☐ Teeth Sensitive to Hot
- ☐ Teeth Sensitive to Sweets
- ☐ Teeth Sensitive to Pressure
- ☐ Texture of Toothbrush_____
- ☐ TMJ Disorder
- ☐ Unfavorable Dental Experience
- ☐ Unusual Sounds in Ear While Eating
- ☐ Water Jet Device
- ☐ How often do you brush your teeth?_____
- ☐ How often do you brush your tongue?_____

**Do you need to pre-medicate before dental treatment? ____YES ____NO**

If you have a history of rheumatic heart disease, hip or knee replacement, mitral valve prolapse, or metal bars or screws implanted in your body, you may be required to pre-medicate with antibiotics prior to your dental visit.

# MEDICAL HISTORY

PHYSICIAN'S NAME_____ ADDRESS_____

PHYSICIAN'S PHONE NUMBER_____DATE OF LAST PHYSICAL_____

**MANY DISEASES ARE FIRST DIAGNOSED IN THE MOUTH SO WE NEED TO KNOW IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING**

- ☐ Aids/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valve
- ☐ Artificial Joints (hip or knee)
- ☐ Asthma
- ☐ Attention Deficit Disorder
- ☐ Back Problems
- ☐ Bleeding Abnormally from Cut or Tooth Extraction
- ☐ Blood Disease
- ☐ Breathing Difficulties
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Chronic Fatigue Syndrome
- ☐ Circulatory Problems
- ☐ Claustrophobia
- ☐ Cortisone Treatments
- ☐ Cough, Persistent or Bloody
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Fainting or Dizziness
- ☐ Gastric Acid Reflux (GERD)
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ Hormone Replacement Therapy
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Low/High Blood Pressure
- ☐ Lyme Disease
- ☐ Mitral Valve Prolapse
- ☐ Neurological Problems
- ☐ Pacemaker
- ☐ Panic Disorder
- ☐ Parkinson's Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Neck Glands
- ☐ Systemic Lupus
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor on Head or Neck
- ☐ Weight Loss, Unexplained
- ☐ Recent Surgery?
  Date _____

**MEDICATIONS**

List any medications you are currently taking, current treatment, and correlating diagnosis. Please include birth control pills, herbal supplements, and aspirin. (Please be advised that antibiotics can negate the effects of birth control pills.)

_____
_____
_____
_____
_____
_____
_____

**ALLERGIES**

- Aspirin
- Barbiturates
- Codeine
- Food
- Sulfa
- Latex
- Local Anesthetic
- Penicillin
- Seasonal

OTHER:_____
_____
_____

**APPOINTMENTS:** A minimum charge will be made for failed or cancelled appointments without prior notice of 48 hours. Once an appointment has been made please remember this time has been reserved for you.

**INSURANCE**: To avoid any misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient. Payment is due at the time that services are rendered. To help you obtain your dental benefits, we will advocate on your behalf and will help fill out your claim forms and provide any x-rays necessary so that you receive maximum reimbursement from your insurance company.

SIGNATURE_____ DATE_____

Parent or guardian if patient is a minor

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# PATIENT CONFIDENTIALITY

In this office, **Patient Confidentiality** is a prime concern. Please indicate below how we may contact you:

How may we contact you to remind you of your ***appointments****?* Which do you prefer the most for regular contact?:

| | YES | NO | PREFER |
|---|---|---|---|
| Text message to mobile phone | ____ | ____ | ____ |
| Voicemail on mobile phone | ____ | ____ | ____ |
| Home | ____ | ____ | ____ |
| Home answering machine | ____ | ____ | ____ |
| Work | ____ | ____ | ____ |
| Email | ____ | ____ | ____ |

Should a family member, friend, or relative contact our office, we are not at liberty to discuss your situation unless we have permission from you, the patient.
With whom may our office ***leave a message***?

| | YES | NO |
|---|---|---|
| Spouse/Partner | ____ | ____ |
| Children | ____ | ____ |
| Parent | ____ | ____ |
| Significant Other | ____ | ____ |

If applicable, name and phone number: _____

_____ _____

PATIENT NAME DATE

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have reviewed a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

**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)

_____

_____

_____

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# Office Policy Regarding Payment of Services

Patient Name_____ Today's Date_____

In order to maintain optimal relationships between staff and patients and to avoid misunderstandings regarding our payment policies, we ask that you read and sign the following:

**When Payments are Due:**
Payment is due in full at the time services are rendered, unless prior arrangements have been made.

**Dental Insurance:**
Please understand that should you have coverage, we do not accept assignment of benefits from your insurance company. It is our responsibility to advocate on your behalf and help you maximize your coverage. We will gladly help you in filling out your claims and providing any supporting documentation (such as x-rays, clinical photographs, and narratives), to help you get maximum reimbursement from your insurance company. You are ultimately responsible to the practice for payment on all services regardless of insurance coverage.

It is your responsibility to know the provisions of your insurance plan. It is also your responsibility to provide updated and accurate demographic and insurance information at each visit. Failure to do so may result in delays in your reimbursement. We thank you for your cooperation in this matter.

Your signature below indicates that you have read and understand the above policy.

_____

Signature of Patient or Legal Guardian