Thank you for visiting our Chester Family Dentistry office. We want your visit to be pleasant and comfortable. Please help us by completing this form.

All of this information is completely confidential.

Patient Information

Full Name (Last, First, Initial):	,
Preferred Name:	
Address:	
City State, Zip:	,
Phones:	**Home-** **Work-** **Cell-**
E-mail Address:	
Soc Sec #:	
Sex:	Male Female
Date of Birth:	
Marital Status:	Single Married Widowed Separated Divorced
Patient Employer/Occupation:	
Emergency Contact:	
Spouse's Name:	
Spouse's Employer/Occupation:	
How did you hear about our office?	

Responsible Party Information

Person Financially Responsible:	
Relation to patient:	
Address:	
City State, Zip:	,
Phones:	**Home-** **Work-**
Employer:	
Soc Sec #:	
Date of Birth:	

Dental Insurance Information

Is patient covered by dental insurance?	Yes No
(If yes, please complete the following:)	
Policy Holder Name:	
Relation to Patient:	
Address:	
City State, Zip:	,
Phones:	**Home-** **Work-**
Soc Sec #:	
Date of Birth:	
Insurance Company Name:	

Insurance Company Phone:	
Group #:	
Subscriber ID#:	

Is patient covered by <u>additional</u> dental insurance?	◯ Yes ◯ No
(If yes, please complete the following:)	

Policy Holder Name:	
Relation to Patient:	
Address:	
City State, Zip:	,
Phones:	**Home-** **Work-**
Employer:	
Soc Sec #:	
Date of Birth:	
Insurance Company Name:	
Insurance Company Phone:	
Group #:	
Subscriber ID#:	

INSURANCE AUTHORIZATION & FINANCIAL RESPONSIBILITY AGREEMENT

I understand that I am financially responsible for all charges whether or not paid by insurance. I assign all insurance benefits directly to the doctor otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature (Parent/Guardian if under age 18) Relationship (if patient is under age 18) Date

Medical History

Patient Name:

Physician's Name:

Phone:

Date of Last Visit:

Please check the box if you have ever had any of the following:

☐ AIDS or HIV positive	☐ Acid Reflux/ G.E.R.D	☐ Arthritis, (Supply Type in Details Below)
☐ Artificial joints	☐ Asthma	☐ Cancer
☐ Chemical Dependency	☐ Diabetes, (Supply Type in Details Below)	☐ Eating disorder
☐ Epilepsy	☐ Excessive bleeding	☐ Glaucoma
☐ Heart Attack	☐ Hepatitis, (Supply Type in Details Below)	☐ Kidney problems
☐ Liver problems or Jaundice	☐ Lung or breathing problems	☐ Sinus trouble
☐ Smoking/chewing tobacco	☐ Stroke	☐ Swollen neck glands
☐ Thyroid problems	☐ Tuberculosis	

Heart Problems:

☐ Artificial valves

Allergies:

☐ Aspirin

Women:

Are you pregnant?

- [ ] Congential heart defects
- [ ] Heart Surgeries
- [ ] High blood pressure
- [ ] Infective (Bacterial) Endocarditis
- [ ] Low blood pressure
- [ ] Pacemaker
- [ ] Other (Supply details below)

- [ ] Codeine
- [ ] Latex
- [ ] Local anesthetic
- [ ] Penicillin
- [ ] Sulfa

Other Allergies:

- ◯ No
- ◯ Yes

Due when?

Are you nursing?

- ◯ No
- ◯ Yes

- [ ] Antibiotics for dental treatment
- [ ] Currently under a physician's care
- [ ] Serious illnesses/hospitalizations

Medications: Please list medications you are currently taking and why

TREATMENT AUTHORIZATION

I have reviewed the information on this form and it is accurate to the best of my knowledge. I authorize and give consent for the dentist and/or team of this office to perform dental services as agreed between doctor and patient and/or guardian, including the use of local anesthetic and other medication as indicated.

Signature (Parent/Guardian if under age 18) Relationship (if patient is under age 18) Date