WELCOME TO PELHAM HILLS DENTISTRY **All information is confidential**

Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Dr. ☐ ADULT ☐ CHILD ☐

Name:_____ Prefers to be called_____
Last First Initial

Address:_____
Street Apt# City Postal Code

Home phone: (_____) _____ - _____ Date of Birth: M_____D_____Y_____ Male ☐ Female ☐

Employer: _____Phone: (_____) _____ - _____ Occupation:_____
School: _____Grade:_____
Would you be available on short notice for future appointments or appointment changes?_____ May we call you at work? _____
Email: _____ Whom may we thank for referring you to our office?_____

Family Physician: _____ Phone: (_____) _____ - _____

In case of emergency:_____ Relation: _____ Phone: (_____) _____ - _____

Person responsible for this account: Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other: _____
Name:_____ Prefers to be called_____
Last First Initial

Address:_____
Street Apt# City Postal Code

Home phone: (_____) _____ - _____ Work phone: (_____) _____ - _____ _____
Drivers License Number

Payment by: Cash ☐ Cheque ☐ Credit Card: _____ Number_____ Exp._____

PRIMARY INSURANCE	SECONDARY INSURANCE
Subscriber: _____	Subscriber: _____
Relation: Self ☐ Spouse ☐ Other:_____	Relation: Self ☐ Spouse ☐ Other:_____
Insurance Co: _____	Insurance Co: _____
Policy/Plan #_____Division/Sect#:_____	Policy/Plan #_____Division/Sect#:_____
Subscriber ID or S.I.N. #:_____	Subscriber ID or S.I.N. #:_____
Are you familiar with your plan details? Yes □ No □	Are you familiar with your plan details? Yes □ No □
Coverage A: _____ B_____C_____ D_____	Coverage A: _____ B_____C_____ D_____

MEDICAL HISTORY All information is confidential

Y =Yes ? =Don't know/Maybe N = No

The following information is required by the dentist to assist in proper diagnosis and treatment	Y	?	N
1. Have you ever had a serious illness requiring hospitalization or extensive medical care? Please specify: _____	☐	☐	☐
2. Have you been hospitalized in the last 5 years?	☐	☐	☐
3. Are you presently under the care of a physician? If yes, why?_____	☐	☐	☐
4. Have you had medical examination in the last year?	☐	☐	☐
5. Do you use any prescription or non-prescription drugs regularly? Please specify: 1) _____ 2) _____3) _____ 4) _____5) _____ 6) _____7)_____	☐	☐	☐
6. Do you have any allergic conditions: i.e. Hay fever, skin rash, food allergies, metal, latex? Please specify:_____	☐	☐	☐
7. Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea? Please specify:_____	☐	☐	☐
8. Have you ever experienced any unusual reaction to any of the following (please circle) Local anesthesia (freezing), aspirin, penicillin, codeine, sulpha drugs, barbiturates (sleeping pills), or any other medicine? Have you ever taken medication to increase bone density? If so, please explain_____	☐	☐	☐
9. Have you been warned against taking any drug or medication?	☐	☐	☐
10. Do you bruise easily or bleed abnormally? Are you on blood thinners?	☐	☐	☐

MEDICAL HISTORY continued	Y	?	N
11. Have you ever had an organ transplant or medical implants?	☐	☐	☐
12. Have you ever fainted?	☐	☐	☐
13. Do your ankles swell during the day?	☐	☐	☐
14. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	☐	☐	☐
15. Do you have frequent headaches / earaches / ear or throat infections or hearing difficulty?	☐	☐	☐
16. Do you have AIDS or had contact with the AIDS virus or have you ever tested positive for HIV?	☐	☐	☐
17. Do you have or have you ever had any of the following? (please circle)	☐	☐	☐
Heart murmur or Mitral valve prolapse / Malignant hyperthermia / Liver disease / Sinus trouble Stroke Stomach / Intestinal problems / Ulcers / Drug / Alcohol dependency / Heart attack / Kidney problems Joint replacement (hip, knee, etc) / Venereal disease / Cold sores / Emphysema Mental or nervous disorder / Lung disease (i.e. asthma) / Jaundice / Glaucoma High / Low blood pressure / Thyroid disease / Diabetes / Other:_____ Hyper / Hypo glycemia / Arthritis or Rheumatism / Tuberculosis / _____ Epilepsy or seizures / Scarlet or Rheumatic fever / Hepatitis A / B / C / _____ Cortisone / Steroid therapy / Cancer / Chemotherapy / Herpes			
18. Have you had any injury, surgery or x-ray therapy to your face or jaws?	☐	☐	☐
19. Do you have any other disease, condition, or problem that you think the doctor should know about?_____	☐	☐	☐
20. WOMEN ONLY — Are you pregnant or suspect you might be? If so, what month are you in? _____	☐	☐	☐
Are you taking birth control pills?	☐	☐	☐
Are you nursing?	☐	☐	☐

DENTAL HISTORY

Y =Yes ? =Don't know/Maybe N = No

1. Reasons for today visit: Exam □ Cleaning □ Emergency □ Other_____	Y	?	N
Are you presently having dental pain?	☐	☐	☐
Is there a dental problem you would like to take care of as soon as possible? Please specify:_____	☐	☐	☐
2. How frequently do you see your dentist? 6 months ☐ Yearly ☐ Other_____ Previous Dentist: _____ Last dental Visit:_____ Last cleaning: _____ Last X-rays:_____	☐	☐	☐
3. How often do you brush your teeth? _____ Floss?_____	☐	☐	☐
4. Do your gums bleed when: (please circle) brushing, flossing, spontaneously	☐	☐	☐
5. Are your teeth sensitive to: (please circle) Hot, Cold, Pressure (chewing), Sweets	☐	☐	☐
6. Do you smoke (please circle) Cigarettes, Cigars, Pipe, or chew? How many per day? ___How many years?___	☐	☐	☐
7. Have you ever had jaw joint surgery?	☐	☐	☐
8. Do you have pain in your jaw joints or suffer from migraine headaches?	☐	☐	☐
9. Does any part of your mouth hurt when clenched?	☐	☐	☐
10. Does your jaw crack or pop when opened widely?	☐	☐	☐
11. Have you had: Braces ☐ Oral surgery ☐ Gum treatment ☐ Root canal ☐	☐	☐	☐
12. Do you grind or clench your teeth during the night?	☐	☐	☐
13. Have you ever experienced any growths or sore spots in your mouth? If so, where?	☐	☐	☐
14. Have you had previous problems with dental treatment? Please specify:_____	☐	☐	☐
15. Are satisfied with the appearance of your teeth? Please specify:_____	☐	☐	☐
16. Do you have any other dental concerns?_____	☐	☐	☐

Office Policy: Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 2 (two) business days notice to avoid charge for the time lost.

I, the undersigned, certify that I have provided an accurate and complete, personal and medical- dental history and have no knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. Should there be any change in either my health status or any other information I have provided, I will advise this dental office. I authorize the dentist to perform diagnostic procedures as my be required to determine necessary. I have been advised of the privacy policy of the office and that determine personal information will be collected, used and disclosed with the guidelines of the policy. I understand that responsibility for payment of the dental service for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

_____ _____

Signature Patient □ Parent □ Guardian □ Reviewing Dentist

Please Print Name: _____ Date:_____