Norwalk DentalCare

GENERAL INFORMATION

ABOUT YOU

Date: ____________________

Name ____
LAST FIRST MI MR MRS MS DR

I prefer to be called: ____________________

Social Security Number: ____________________

Birthdate: __________ Age: ______

Gender: ☐ Male ☐ Female ☐ Gender neutral

Home Address: ____
HOUSE /APT. / CONDO #

____
CITY STATE ZIP

Contact no.: ____________________

E-mail Address: ____________________

How do you prefer to be contacted? ☐ E-mail ☐ Phone ☐ Text

Employer: ____________________

Occupation: ____________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Seperated

Other family members seen by us: ____________________

Previous/Present Dentist: ____________________

Last Visit Date: ____________________

Whom may we thank for referring you? ____________________

INSURANCE COVERAGE

Primary

Dental Coverage: ☐ Yes ☐ No

Isurance Co. Name: ____________________

Isurance Co. Phone #: ____________________

Group # (Plan/Policy): ____________________

Insured's Name: ____________________

Relation: __________ DOB: __________

Insured's ID#: ____________________

Insured's Employer: ____________________

Are you financially responsible for this account?

☐ Yes ☐ No

Secondary

Dental Coverage: ☐ Yes ☐ No

Isurance Co. Name: ____________________

Isurance Co. Phone #: ____________________

Group # (Plan/Policy): ____________________

Insured's Name: ____________________

Relation: __________ DOB: __________

Insured's ID#: ____________________

Insured's Employer: ____________________

SPOUSE INFORMATION

His/ Her Name: ____________________

Employer: ____________________

SS #: __________ Birthdate: __________

Person Responsible for Account: ____________________

SS#: __________ Contact #: __________

Employer: ____________________

Billing Address: ____________________

EMERGENCY CONTACT

In an event of emergency, is there someone we should contact?

Name: ____________________

Relation: ____________________

Work #: __________ Cell #: __________

CONTINUED ON BACK

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MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ____________________ Phone No.: __________ Date of last visit: __________

Are you currently under the care of a physician? ☐ Yes ☐ No If yes, why? ____________________

____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list all: ____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

For Women:

Are you pregnant? ☐ Yes ☐ No Week#: ____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following conditions?

☐ Alcohol/ Drug Abuse
☐ Anemia
☐ Arthritis
☐ Artificial Joint/ Heart Valve
☐ Asthma
☐ Blood Transfusion
☐ Cancer/ Chemotherapy
☐ Colitis
☐ Congenital Heart Defect
☐ Diabetes
☐ Difficulty Breathing
☐ Emphysema
☐ Epilepsy
☐ Fainting Spells
☐ Frequent Headaches
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack
☐ Heart Murmur
☐ Heart Surgery
☐ Hemophilia
☐ Hepatitis
☐ Herpes / Fever Blisters
☐ High Blood Pressure
☐ HIV + / AIDS
☐ Hospitalized Anytime
☐ Kidney Problems
☐ Liver Disease
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Psychiatric Problems
☐ Radiation Treatment
☐ Rheumatic Fever
☐ Seizures
☐ Shingles
☐ Sickle Cell Disease/Traits
☐ Sinus Problems
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis (TB)
☐ Ulcers
☐ Venereal Disease

Please list any serious medical condition(s) that you have ever had: ____________________

____

Are you allergic to any of the following?

☐ Aspirin
☐ Codeine
☐ Dental Anesthetics
☐ Erythromycin
☐ Jewelery
☐ Latex
☐ Metals
☐ Penicillin
☐ Tetracycline

Please list any other drugs/ material that you are allergic to: ____________________

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GENERAL INFORMATION

DENTAL HEALTH

Why have you come to the Dentist today?

____

____

____

Approximate date of last dentist visit: ____________

When woud you like us to start treatment?

____

Any serious problems with previous dental treatment or any dental emergencies?

____

Reason for changing dental practice (if any) ?

____

Do you feel that you have bad breath? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Do your gums feel tender/swollen? ☐ Yes ☐ No

Have you experienced pain/ discomfort in your jaw joint (TMJ/ TMD) ? ☐ Yes ☐ No

How often do you brush your teeth? ________

How often do you floss? ________

What type of brush do you use? ☐ Powered ☐ Manual

Do you avoid brushing any part of your mouth because of pain? ☐ Yes ☐ No

If yes, what part? ______________________

What food causes you twinges of pain? ☐ Hot ☐ Cold ☐ Sweet ☐ Sour ☐ None

Do you chew on only one side of your mouth? ☐ Yes ☐ No

If yes, explain? : ______________________

Do you clench or grind your jaws while sleeping or during the day? ☐ Yes ☐ No

Do your jaws feel tired? ☐ Yes ☐ No

COSMETIC EVALUATION

Do you like your smile? ☐ Yes ☐ No

Please rate your smile from 1 to 10 : ________

(1= I hate my smile, 10= I love my smile)

Would you like to have whiter teeth?

☐ Yes ☐ No

What personal or professional benefits might you gain with a better smile? ______________

____

Do you have any special occasions coming up?

☐ Yes ☐ No

Would you like to see what you would look like with a new and improved smile through **Dental Imaging** and **Digital Photography?** ☐ Yes ☐ No

Please add anything you feel is important:

____

____

I understand that the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the release of information to insurance carriers and other health care professionals who are involved in my care. I assign my insurance benefits unless otherwise indicated. I have received a copy of HIPAA Law and Dental Material form as well as releasing Dr. Chopra to utilize any dental Photographs for lecturing or educational purposes.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

____

Signature Date

Our practice is HIPAA Compliant and committed to meeting or ecxeeding the standards of infection control mandated by OSHA, the CDC and the ADA