CHATHAM DENTAL, PLLC

Patient Information Date: _____/_____/_____

Name: _____ SS#_____

Date of Birth ___/___/___ Sex: Male/Female

Address: _____ City _____ State _____ Zip _____

Home Phone: (____) ____-_____ Work Phone: (____)_ ___-_____ Cell Phone: (____)____-_____

Marital Status: Single/ Married/ Divorced/ Domestic Partner/ Widow/ Minor

Preferable time: Early Morning/ Late Morning/ Early Afternoon/Late Afternoon/Any time

In case of Emergency: _____ Phone: _____

Relationship to Patient: _____ Cell Phone: _____

Insurance Information:

Primary Insurance Information:

Insurance Company: _____

Policy Holder: _____ SS#____-____-_____ DOB ___/___/_____

Policy Holder's Employer: _____

ID#_____ Group#_____ Relationship to holder: _____

Secondary Insurance Information (leave blank if not applicable):

Insurance Company: _____

Policy Holder: _____ SS#____-____-_____ DOB ___/___/_____

Policy Holder's Employer: _____

ID#_____ Group#_____ Relationship to holder: _____

ASSIGNMENT AND RELEASE:

I certify that I, and/or my dependent(s), have insurance coverage with the insurance listed above and assign directly to Dr. Colin Heeps all insurance benefits, if any, otherwise payable to me for services rendered. *I understand that I am financially responsible for all charges whether or not paid by insurance.* I authorize the use of my signature on all insurance submissions.

Signature: _____ Print Name:_____

Relationship to patient: _____ Date: _____/_____/_____

Dental Information:

Reason for today's visit: _____

Former Dentist: _____ Date of last: Cleaning_____ X-rays _____

Please check what applies:

__ Bad breath
__ Bleeding gums
__ Blisters on lips or mouth
__ Clicking/popping/pain in jaw
__ Food collection between teeth
__ Grinding teeth
__ Loose teeth/broken fillings
__ Orthodontic Treatment
__ Periodontal Treatment
__ Sensitivity Hot/Cold/Sweets/Biting

How often do you brush?

_____

How often to you floss?

_____

Primary Dental goal:

_____

_____

_____

_____

Medical History:

Primary Care Physician: _____ Phone (____) ____-_____

Please check all that apply:

__ **Abnormal Bleeding**	__ Circulatory Problems	__ Kidney Disease
__ AIDS/HIV	__ Congenital Heart Disease	__ Liver Disease
__ Angina	__ COPD (Emphysema)	__ **Mitral Valve Prolapse**
__ Arthritis	__ Cough, persistent or bloody	__ **Pacemaker**
__ **Artificial Heart Valves**	__ **Diabetes**	__ Psychiatric Care
__ **Artificial Joints**	__ Epilepsy/Seizures	__ Radiation Therapy
__ Asthma	__ Fainting/Dizziness	__ Respiratory Disease
__ Autism	__ Heart Murmur	__ Rheumatic/ Scarlet Fever
__ Back Problems	__ Heart Problems/Surgery	__ Stroke
__ Cancer/Chemotherapy	__ Hepatitis A / B / C	__ Thyroid Problems
__ Celiac Disease	__ Herpes	__ Tonsillitis
__ Chemical Dependency	__ **High/ Low Blood Pressure**	__ Tuberculosis

Do you now or have you ever pre-medicated with antibiotics for dental treatment? YES / NO

If yes, why? _____

Do you now or have you ever taken osteoporosis medications? YES/ NO

If yes, what medication? _____ Currently taking? ____ Ended on ___/___/_____

Do you wear contact lenses? YES / NO

Women Only:

Are you pregnant? YES/ NO If yes, due date: _____/_____/_____

Taking birth control pills? Yes/ No

Allergies

__ Aspirin	__ Jewelry/ Metals	__ Sulfa
__ Codeine	__ **LATEX**	__ Iodine
__Dental Anesthetic	__ Penicillin	__ Other Antibiotics: _____
__ Erythromycin	__ Amoxicillin	__ Other: _____

What pharmacy do you use? _____ Number: (____) ____-_____

Medications: (only names of medications are necessary dosages are not needed)

_____

_____

_____

_____

_____