



Phone: (914) 941-2200

Chilmark Dental P.C.

15 Pleasantville Rd.
Ossining, NY 10562

We are pleased you have selected us to provide dental care for you and your family

Welcome

Email _____ Patient # _____

Cell # _____ Soc. Sec # _____

Today's Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

If Patient is a Student, Name of School / College _____ City _____ State _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency 1) _____ Phone _____

2) _____ Phone _____

3) _____ Phone _____

Relationship

Name of Person Responsible for this Account _____ to Patient _____

Address _____ Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? Yes No

Responsible Party

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much Is Your Deductible? _____ How Much Have You Used? _____ Max Annual Benefit _____

DO YOU HAVE ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much Is Your Deductible? _____ How Much Have You Used? _____ Max Annual Benefit _____

PLEASE COMPLETE OTHER SIDE OF FORM

Patient Medical History

Chilmark Dental, PC
15 Pleasantville Road
Ossining, NY 10562

Physician _____ Office Phone _____ Date of Last Exam _____

- | | Yes | No | | Yes | No |
|----------------------------------------------------------------------------------------|--------------------------|--------------------------|-----------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Are you under medical treatment now?..... | <input type="checkbox"/> | <input type="checkbox"/> | 7. Are you allergic to or have you had any reactions to the following?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness?..... | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (eg. novocaine) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medication(s) including non-prescription medicine?..... | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what medication(s) are you taking? _____ | | | Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you use tobacco?..... | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use alcohol, cocaine or other drugs?..... | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you wearing contact lenses?..... | <input type="checkbox"/> | <input type="checkbox"/> | Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| Date of last TB test _____ | | | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Other | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 8. Women Only: | | |
| | | | a) Are you pregnant or think you may be pregnant?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | b) Are you nursing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | c) Are you taking birth control pills?..... | <input type="checkbox"/> | <input type="checkbox"/> |

- | 9. Do you have or have you had any of the following? | | Yes | No | Yes | No | Yes | No | |
|------------------------------------------------------|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker..... | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles | <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever / Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting / Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Frequently Tired | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy / Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement or Implant | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Diseases | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis / Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease | <input type="checkbox"/> | <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles / Ulcers..... | <input type="checkbox"/> | <input type="checkbox"/> | Cough with Blood | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent Cough | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> | Herpes | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Blood Disorders | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Dental History

- | | Yes | No | | Yes | No |
|-------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing?..... | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you had any orthodontic work?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever had any prolonged bleeding following extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? | | | 14. Have you ever had instruction on the correct method of brushing your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| a) Clicking? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever had instructions on the care of your gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Pain (joint, ear, side of face)? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| c) Difficulty in opening or closing? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| d) Difficulty in chewing? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____
Signature of patient or parent if minor

Doctor's Comments _____

Signature _____ Date _____