Welcome to Windsor Dental

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Dr. Cherian, DDS and the Staff are pleased to welcome you to our practice. Your complete oral health is our main concern. Communication is key to helping us give you a happy, healthy smile. We therefore ask that you complete this form in its entirety.

1 About You

Today's Date: _____

E-mail Address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ❑ Male ❑ Female

Birthdate: __/__/__ Age: _____ SS #: _____

Home Address: _____
APT / CONDO #

_____
CITY STATE ZIP

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Cell #: (___) _____ ❑ Partnered ❑ Minor

Home #: (___) _____ Work #: (___) _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where and when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____

Last Visit Date: _____

2 Spouse Information

Name: _____

Employer: _____

Work #: (___) _____ Ext: ____ SS #: _____

Birthdate: __/__/__ Home #: (___) _____ Cell #: (___) _____

Person Responsible for Account:

Home #: (___) _____ Cell #: (___) _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ Work #: (___) _____

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relation: _____

Work #: (___) _____ Home #: (___) _____

4 Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Phone #: (___) _____ Date of last visit: _____

Are you currently under the care of a physician? ❑ Yes ❑ No

Please Explain: _____

CONTINUED ON BACK

4 MEDICAL HISTORY continued

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

Are you taking any prescription, over-the-counter, or supplement drugs? ❑ Yes ❑ No

Please list each one: _____

_____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you ever taken Fosamax, Actonel, Boniva, or any other bisphosphonate? ❑ Yes ❑ No

Are you using a prescribed method of birth control? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week #: _____

Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems? (Please circle option that applies)

Y N	Anemia/Radiation Treatment	Y N	Hemophilia/Abnormal Bleeding
Y N	Artificial Bones/Joints/Valves	Y N	Hepatitis
Y N	Arthritis	Y N	High/Low Blood Pressure
Y N	Asthma	Y N	HIV+/AIDS
Y N	Blood Transfusion	Y N	Hospitalized for Any Reason
Y N	Cancer/Chemotherapy	Y N	Kidney Problems
Y N	Congenital Heart Defect	Y N	Mitral Valve Prolapse
Y N	Diabetes	Y N	Psychiatric Problems
Y N	Difficulty Breathing	Y N	Rheumatic/Scarlet Fever
Y N	Drug/Alcohol Abuse	Y N	Severe/Frequent Headaches
Y N	Emphysema/Glaucoma	Y N	Shingles
Y N	Epilepsy/Seizures/Fainting Spells	Y N	Sickle Cell Disease/Traits
Y N	Fever Blisters/Herpes	Y N	Sinus Problems
Y N	Heart Attack/Stroke	Y N	Tuberculosis (TB)
Y N	Heart Murmur	Y N	Ulcers/Colitis
Y N	Heart Surgery/Pacemaker	Y N	Venereal Disease

Please list any medications you are currently taking:

_____

_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Erythromycin	Y N	Penicillin
Y N	Codeine	Y N	Jewelry/Metals	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Latex	Y N	Other

Please list any other drugs/materials that you are allergic to: _____

_____

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials:_____Date: _____

Doctor's Comments: _____

_____

We appreciate your effort to fill out this complete form. It will ensure that we can provide the most effective care possible. Please do not hesitate to ask if you have any questions. We are here for you.

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

5 DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ❑ Hard ❑ Medium ❑ Soft

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

_____

Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

ASSIGNMENT AND RELEASE

I certify that, I and/or my dependent(s), have insurance coverage with _____ (name of insurance company) and assign directly to Dr. _____ 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.

The above-named dentist may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agent for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable for related services.

This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Print name of Patient Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient