COMMUNITY HEALTH PROGRAMS DENTAL CENTER

WWW.CHPBERKSHIRES.ORG
Tel: 413-528-5565

PATIENT INFORMATION

Date: ☐NEW PATIENT ☐UPDATE

Patient:
LAST FIRST MI DATE OF BIRTH TITLE

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

EMERGENCY CONTACT INFORMATION

NAME & PHONE NUMBER

Patient Date of Birth:

DENTAL HISTORY

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: Treatment Type:

☐Y☐N Are you currently having dental discomfort? If yes, explain:
☐Y☐N Any injuries to mouth/teeth/head? If yes, explain:
☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?
☐Y☐N Have missing teeth been replaced?
☐Y☐N Orthodontic appliances now or in the past?
☐Y☐N Gums bleed when brushing or flossing?
☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N
☐Y☐N Any concerns about the appearance of your teeth?
☐Y☐N Does it hurt to bite or chew?
☐Y☐N Do you clench or grind your teeth? Does your jaw click? ☐Y☐N
☐Y☐N Do you want your mouth restored and pain free?

What is your reason for your dental visit today?:

What factors are most important for your satisfaction with our office?

Any additional concerns/comments?

DO YOU HAVE ANY OF THE FOLLOWING:

☐Y☐N Active Tuberculosis?
☐Y☐N Persistent cough for more than 3 weeks?
☐Y☐N Cough that produces blood?
☐Y☐N Contact with someone who has active tuberculosis?

If you answered yes to any of the above please stop now and go to the front desk

PRIMARY PHYSICIAN INFORMATION

Physician: Telephone:

Clinic/Facility:

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years?
☐Y☐N Any serious illnesses/surgeries?
☐Y☐N Use tobacco in any form? If Yes, explain:
☐Y☐N History of drug or alcohol use?: If Yes, explain
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y☐N Taking any prescription or daily OTC medications/drugs? Please List Below in medication section

FEMALE PATIENTS: ☐Y☐N Currently nursing ☐Y☐N Currently pregnant ☐Y☐N Birth Control

Gender Identity: ☐Male ☐Female ☐Transgender Male/Female to Male ☐Transgender Female Male to Female ☐Other ☐Choose not to disclose

Sexual Orientation ☐Lesbian or Gay ☐Straight ☐Bisexual ☐Don't Know ☐Choose Not to Disclose

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ALZHEIMERS	☐EMPHYSEMA/COPD	☐HEPATITIS B	☐OSTEOPOROSIS
☐ANEMIA	☐EPILEPSY/SEIZURES	☐HEPATITIS C	☐PACEMAKER
☐ALLERGIES	☐FAINTING OR DIZZY SPELLS	☐HERPES	☐PERSISTENT COUGH
☐ARTHRITIS	☐COLD SORES	☐HIGH BLOOD PRESSURE	☐PSYCHIATRIC TREATMENT
☐ARTIFICIAL HEART VALVE	☐GLANDULAR DISORDERS	☐HIGH CHOLESTEROL	☐RADIATION TREATMENT
☐ARTIFICIAL JOINT(S)	☐GLAUCOMA	☐HIVES	☐RECREATIONAL DRUG USE
☐ASTHMA	☐HAY FEVER	☐HIV POSITIVE/AIDS	☐RHEUMATIC/SCARLET FEVER
☐BACTERIAL ENDOCARDITIS	☐HEADACHES(SEVERE)	☐HODGKIN'S DISEASE	☐SCREWS/PINS/METAL PLATES
☐BLEEDING DISORDER	☐HEAD/NECK INJURIES	☐IMMUNE DISORDER	☐SEXUALLY TRANSMITTED DISEASES
☐BRUISE EASILY	☐HEARING DIFFICULTIES	☐KIDNEY PROBLEMS	☐SINUS PROBLEMS
☐CANCER	☐HEART ATTACK	☐LEUKEMIA	☐STEROID/CORTISONE THERAPY
☐CEREBRAL PALSY	☐HEART DISEASE	☐LIVER DISEASE	☐STROKE
☐CHEST PAIN	☐HEART MURMUR	☐LOW BLOOD PRESSURE	☐SUBSTANCE ABUSE
☐CONGENITAL HEART DEFECT	☐HEART SURGERY	☐LUNG DISEASE	☐THYROID PROBLEMS
☐CONGESTIVE HEART DISEASE	☐HEMOPHILIA	☐MALIGNANT HYPERTHERMIA	☐ULCERS
☐DIABETES	☐HEPATITIS A	☐MITRAL VALVE DISEASE	☐OTHER:

MEDICATION INFORMATION

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING BELOW.

DRUG NAME	DOSAGE	DRUG NAME	DOSAGE

ASA CLASSIFICATION: I □ II □ IV*□ *MEDICAL CONSULT REQUESTED? □ YES □ NO DATE REQUESTED_____

TO THE BEST OF MY KNOWLEDGE, ALL OF THE INFORMATION I HAVE PROVIDED ON THIS FOR IS TRUE AND CORRECT. IF I EVER HAVE ANY CHANGES IN MY HEALTH OR MEDICATIONS, I WILL INFORM THE DENTIST OR HYGIENIST PRIOR TO ANY TREATMENTS.

PATIENT/GUARDIAN SIGNATURE:_____ DATE:_____

PROVIDER SIGNATURE:_____ DATE:_____