

Welcome To Our Practice

We strive to be great relationship builders. One of our top priorities is taking the time to get to know you—offering a listening ear and treating you as a person rather than just another set of teeth to clean and fix. Why? Because in today's fragmented world it might seem that dental health and overall well-being aren't related. We are certain that they are.

Patient Information

Patient Name: _____ Date: _____
Last First MI Preferred Name

Male Female Child Single Married Divorced Widowed Separated

Social Security #: _____ DOB: _____ Email: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Your Address: _____
Street City State Zip

Employer Name: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Cell: _____ Relation: _____

Berkshire Dental Group

Health Information

Have you ever had any of the following? Please check those that apply:

<input type="checkbox"/> Allergies to: _____ <input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> Dental Anesthetics <input type="checkbox"/> Erythromycin <input type="checkbox"/> Jewelry / Metals <input type="checkbox"/> Latex <input type="checkbox"/> Penicillin <input type="checkbox"/> Tetracycline <input type="checkbox"/> Other _____	<input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Cancer/Chemotherapy <input type="checkbox"/> Diabetes <input type="checkbox"/> Dental Anxiety <input type="checkbox"/> Epilepsy / Seizures <input type="checkbox"/> Emphysema <input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> Fever Blisters/ Herpes <input type="checkbox"/> Glaucoma <input type="checkbox"/> Heart Attack / Stroke <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Surgery/Pacemaker <input type="checkbox"/> Hepatitis <input type="checkbox"/> High / Low Blood Pressure <input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Hospitalization <input type="checkbox"/> Jaundice <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Liver Problems <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Nervous Disorders <input type="checkbox"/> Phen-Fen Diet Pills <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Radiation Treatment <input type="checkbox"/> Respiratory Problems <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Severe Headaches <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Current Smoker/Dipper <input type="checkbox"/> Tuberculosis (TB) <input type="checkbox"/> Tumors <input type="checkbox"/> Ulcers / Colitis <input type="checkbox"/> Venereal Disease OTHER: <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ WOMEN: Are You Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes #of Weeks _____
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Anemia
 Arthritis
 Artificial Joints/Valves
 Asthma

- Do you have any health problems that need clarification? Yes No
If yes, please explain: _____
- Do you require antibiotic premedication Yes No
- Name of Physician: _____ Phone: _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Please list **any** prescription, over-the-counter drugs, vitamins, or herbal supplements you are taking: _____
- Whom may we thank for referring you to our practice? Another patient, friend, or relative Dental Office
 Internet Yellow Pages Newspaper / Magazine School Work Other _____
Name of person or office referring you to our practice: _____
- What are your personal interests or hobbies? _____
- In accordance with HIPAA, by signing below, I authorize the release of information regarding my dental treatment (or my minor child or dependent) to referring care providers and insurance carriers or a designated family member.
Designated family member name: _____

Signature of patient, parent or guardian

Date

Signature of Berkshire Dental Group Staff Member

Dental Information

Why have you come to the dentist today? _____

- Yes No Has your doctor ever told you that you require antibiotics before dental treatment ?
- Yes No Have you ever had a serious / difficult problem associated with any previous dental work ?
- Yes No Do you have, or have you ever experienced pain /discomfort in you jaw joint (TMJ / TMD)?
- Yes No Are you currently having dental pain ? Yes No Have you ever had a toothache ?
- Yes No Have you ever fractured or cracked a tooth ?
- Yes No Are you concerned about your silver / mercury fillings ?
- Yes No Have you noticed spots, stains, or chips on your teeth that concern you ?
- Yes No Are you pleased with the appearance or your smile ?
- Yes No Have you ever considered whitening your teeth ?
- Yes No Have you ever considered straightening your teeth ?
- Yes No Do you have any place where food catches between your teeth or areas that are difficult to floss ?
- Yes No Have you ever been told that you have, or have you ever been treated for, gum disease (pyorrhoea) ?
- Yes No Do your gums ever bleed ?

How many times a day do you brush your teeth ? _____ What do you use to clean between your teeth ? _____

How would you rate your dental health ? Excellent Good Fair Poor

What is your current Height? _____ Weight ? _____ Date of last cleaning/exam: _____

What did you like most about any dentist you have seen ? _____ Least ? _____

Why did you leave your previous dentist ? _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ DOB: _____ SSN: _____

Address: _____

Phone (Home): _____ (Cell): _____

Employer Name: _____ Work Phone: _____

Relationship to Patient: _____

Insurance Information

Name of Insured: _____ DOB: _____ SSN: _____

Insured's Address: _____ Phone: _____

Insured's Employer Name: _____ Phone: _____

Insurance Company Name: _____ Phone: _____

Group #: _____ Insured's ID #: _____

Consent for Services

With my signature below, I authorize:

- the dental staff of Berkshire Dental Group to perform any necessary dental services required during my diagnosis and treatment, with my informed consent.
- the use of photographs of myself and my dental treatment in scientific articles, publications, and/or presentations.
- the release of any information necessary to process insurance claims.
- if I request payment arrangements for services rendered, the generation of a credit report

Signature of patient, parent or guardian Date