Welcome

Thank you for selecting Katonah Dental. We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs please fill out this form completely in ink. If you have any questions or need assistance, please ask us we will be happy to help you.
Katonahdental.com

Patient Information (CONFIDENTIAL)

Date_____

Name_____
Birth date_____ SS#_____
Address_____ City_____ State____ Zip_____
Home Phone_____ Cell Phone_____ Work Phone_____
Email_____
Are there any family members that are patients at Katonah Dental Group Yes __ No__
Whom May We Thank for Referring You? _____
If Student, Name of School/College_____City_____ State___Full Time__ Part Time__
Spouse or Parent/Guardian's Name_____ Work Phone _____
Person to Contact in Case of Emergency _____Phone _____

Responsible Party

Name of Person Responsible for this Account _____Relationship _____
(First) (M.I.) (Last) to Patient
Address_____
Birth date_____SS#_____
Home Phone_____Cell Phone_____Work Phone _____
Email _____

Dental Insurance Information

Name of Insured_____Relationship _____
(First) (M.I) (Last) to Patient
Birth date_____ SS#_____ Home Phone_____
Name of Employer_____Union or Local #_____Home Phone_____
Insurance Company_____Group#_____ Policy/ID#_____
Ins. Co. Address_____City_____State_____Zip_____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? Yes____ No___ IF YES, COMPLETE THE FOLLOWING:

Name of Insured_____Relationship_____
(First) (M.I) (Last) to Patient
Birth date_____ SS#_____ Home Phone_____
Name of Employer_____Union or Local #_____ Home Phone_____
Insurance Company_____Group#_____Policy/ID#_____
Ins. Co. Address_____ City_____State_____Zip_____

Over Please

Patient Medical History

Physician_____Office Phone_____Date of Last Physical_____

1. Are you under medical treatment now?.. Yes__ No__
2. Have you been hospitalized for any reason within the last 5 years?..... Yes__ No__
   If yes Please explain_____
   _____
3. Are you taking any medication(s) including non-prescription medicine?..... Yes__ No__
   If yes what medication(s) are you taking
   _____
   _____
4. Do you use tobacco?..... Yes__ No__
5. Do you use controlled substances?..... Yes__ No__

6. Are you allergic to or have you had any reactions to the following?
   Local Anesthetics (e.g. Novocain).....Yes__ No__
   Penicillin or other Antibiotics.....Yes__ No__
   Sulfa Drugs .....Yes__ No__
   Barbiturates.....Yes__ No__
   Sedatives.....Yes__ No__
   Aspirin.....Yes__ No__
   Any Metals (e.g. nickel, mercury,etc.)Yes__ No__
   Latex Rubber.....Yes__ No__
   Other(please list)_____
7. Women Only:
   a. Are you pregnant or think you may be pregnant?.....Yes__ No__
   b. Are you nursing?..... .....Yes__ No__
   c. Are you taking oral contraceptive?... Yes__ No__

8. Do you have or have you had any of the following?

AIDS or HIV infection Yes__ No__ Anemia Yes__ No__
Angina..... Yes__ No__ Anorexia/Bulimia Yes__ No__
Arthritis .....Yes__ No__ Asthma Yes__ No__
Cancer.....Yes__ No__ Cardiac Pacemaker Yes__ No__
Chemical/Alcohol Dependency.....Yes__ No__
Chest pains Yes__ No__ Diabetes Yes__ No__
Emphysema.....Yes__ No__
Epilepsy/Convulsions.....Yes__ No__
Excessive/Prolonged Bleeding.....Yes__ No__
Fainting/Seizures.....Yes__ No__
Hay Fever/Allergies.....Yes__ No__
Heart Attack Yes__ No__ Heart Disease Yes__ No__
Heart Murmur Yes__ No__ Heart Trouble Yes__ No__
Hepatitis/Jaundice.....Yes__ No__
If yes what type_____
High Blood Pressure.....Yes__ No__
Joint Replacement or Implant.....Yes__ No__
Kidney Disease Yes__ No__ Leukemia Yes__ No__
Liver Disease Yes__No__ Low Blood Pressure Yes__No__
Mitral Valve Prolapse..... Yes__ No__
Psychiatric Care/Depression.....Yes__ No__
Radiation Therapy .....Yes__ No__
Respiration Problems..... Yes__ No__
Rheumatic Fever..... Yes__ No__
Sexually Transmitted Disease..... Yes__ No__
Stomach Troubles/Ulcers..... Yes__ No__
Stroke Yes__ No__ Thyroid Problem Yes__ No__
Tuberculosis Yes__ No__ Other_____ Yes__ No__

Patient Dental History

Name of Previous Dentist and Location_____Date of Last Exam_____

1. Do your gums bleed while brushing or flossing?..... Yes__ No__
2. Are your teeth sensitive to hot or cold liquids/food?..... Yes__ No__
3. Are your teeth sensitive to sweet or sour liquids/foods?.....Yes__ No__
4. Do you feel pain to any of your teeth?... Yes__ No__
5. Do you have any sores or lumps on or near your mouth?,..... Yes__ No__
6. Have you had any head, neck or jaw injuries?..... Yes__ No__
7. Have you ever experienced any of the following problems in your jaw?
   Clicking?..... Yes__ No__
   Pain (joint, ear, side of face)?..... Yes__ No__
   Difficulty in opening or closing?..... Yes__ No__
   Difficulty in chewing?.....Yes__ No__
8. Do you have frequent headaches?.....Yes__ No__
9. Do you clench or grind your teeth?..... Yes__ No__
10. Have you ever had any difficult extractions in the past?..... Yes__ No__
11. Have you ever had prolonged bleeding following an extraction?..... Yes__ No__
12. Have you had orthodontic treatment?....Yes__ No__
13. Do you wear dentures or partials?..... Yes__ No__
    If yes, date of placement_____
14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?..... Yes__ No__
15. Do you like your smile?..... Yes__ No__
16. Do you use a Sonicare toothbrush?..... Yes__ No__
17. Do you have any current X-Rays?.....Yes__ No__

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/guardian if minor)

Doctor's Signature_____Date_____