ABOUT YOU

Today's Date ____/_____/_____ Name:_____I prefer to be called: _____
Male ☐ Female ☐ Are you: Single ☐ Married ☐ Child ☐ Other ☐
Birthdate: _____/_____/____ __Age _____ SS# _____
Home Address:_____
_____
Hm#_____ Cell#_____ Work#_____
Email: _____ Employer_____
Where and When are the best times to reach you?_____
May we leave a message on your Home Phone?_____Cell Phone? _____ Work Phone?_____
Whom may we thank for referring you?_____
When contacting you what is the best method to do so: Phone call ☐ E-Mail ☐ Text Message ☐

SPOUSE INFORMATION

His/Her Name_____ Employer:_____
Work Phone: _____
Birthdate: _____
Person responsible for the account: _____
Billing address:_____
_____ Relationship:_____ SS# _____
Employer:_____

DENTAL INFORMATION

Why have you come to see us today?_____
Last dental visit date:_____
Are you currently in pain?_____
Are your teeth sensitive to cold, hot, sweets or pressure?_____
Is your mouth dry? _____
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?_____
Have you ever had any TMJ treatment?_____
Do you wear a night guard or a bite guard?_____
Are you self conscious about your teeth?_____
If you could change anything about your teeth, what would it be_____
_____
Have you ever had any previous dental work that you weren't pleased with the outcome_____
_____
Are your teeth getting more crowded?_____
Do you have any cracks, chips or pits that you are aware of?_____
Do you use a CPAP or an appliance in your mouth for Sleep Apnea_____
How well do you sleep?_____
Have you ever been told you snore or stop breathing at night?_____

DENTAL HYGIENE INFORMATION

Does food or floss catch between your teeth?_____
How many times a week do you floss?_____
How many times a day do you brush?_____
How often do you change your toothbrush?_____
Do your gums bleed when you brush or floss?_____
Do you see any areas where the gums are receeding?_____
Have you noticed any teeth becoming loose?_____
Have you had a bad taste or bad breath?_____
Have you ever had gum/periodontal treatments?_____
Have you ever lost any teeth?_____Why?_____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there a may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Answer All Questions by checking Yes (Y) or No (N)

All Responses are kept confidential

	Y	N
Are you in good health?	☐	☐
Has there been any change in your health in the last year?	☐	☐
My last physical exam was on _____/_____/_____		
The name of my Primary Care Physician is _____		
Are you currently or have you ever been under the care of any other physicians?	☐	☐
_____		
_____		
_____		
Have you had any serious illness, operation or hospitalization in the last 5 years?	☐	☐
_____		
Have you had an artificial joint replacement?	☐	☐
Are you taking or have you taken Bisphosphonates for osteoporosis or chemotherapy for Multiple Myeloma or other cancers? *(Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia)*	☐	☐
Are you taking any medicines including diet pills, non-prescription, vitamins, homeopathic, or natural remedies? **If so please list on the end of the page.**	☐	☐

Do you have or have you had any of the following problems:

Damaged heart valves	☐	☐
Rheumatic Fever	☐	☐
Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition?	☐	☐
Chest pain upon exertion	☐	☐
Shortness of breath upon mild exercise	☐	☐
Do your ankles swell	☐	☐
Allergies	☐	☐
Sinus trouble	☐	☐
Asthma, hay fever	☐	☐
Fainting spells or seizures	☐	☐
Diabetes	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Frequent or recurrent mouth sores	☐	☐
Thyroid problems	☐	☐
Respiratory problems, emphysema, bronchitis, etc.	☐	☐
Arthritis or painful swollen joints	☐	☐
Painful TMJ or headaches	☐	☐
Osteoperosis	☐	☐
Stomach Ulcer	☐	☐
Kidney trouble	☐	☐
Tuberculosis	☐	☐
Low blood pressure	☐	☐
Epilepsy or neurological disorder	☐	☐
Cancer	☐	☐
Eating Disorders	☐	☐
Sleep Disorders	☐	☐
HIV or Hepatitis	☐	☐
Have you ever had radiation to the head, neck or jaws?	☐	☐
Do you have to wear hypoallergenic jewelry to avoid skin reaction?	☐	☐

Are you allergic to or have you ever had a reaction to:

Local anesthetics	☐	☐
Penicillin or Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates or Sleeping pills	☐	☐
Aspirin	☐	☐
Iodine	☐	☐
Codeine or Narcotics	☐	☐
Latex	☐	☐

Have you ever had any serious trouble with dental treatment? If so, please explain:

_____

_____

_____

_____

Do you have any other condition or disease the doctor should know about?

_____

_____

Do you smoke or chew tobacco? How much?_____

_____

Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide for you?	☐	☐
Do you wish to talk to the doctor privately about anything?	☐	☐

WOMEN

Are you pregnant or trying to become pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

PLEASE LIST ALL OF YOUR MEDICATIONS HERE

_____

_____

_____

_____

_____

_____

DENTAL INSURANCE
Do you have the benefit of any dental coverage?

PRIMARY INSURANCE
Insured Name_____ Group #_____
Company Name_____ Relation _____
Insured Birthdate _____/_____/_____
Insured ID # _____ Insured Employer_____

SECONDARY INSURANCE
Insured Name_____ Group #_____
Company Name_____ Relation _____
Insured Birthdate _____/_____/_____
Insured ID # _____ Insured Employer_____

Please bring your dental insurance card to your first appointment with us

Dental Insurance is a contract between the employer and the employee. At Keating Family Dental we will gladly process your insurance forms for you and will apply the insurance benefits you receive toward the total fee of a service. Dental insurance is to offset a portion of the dental treatment. The fee for services is the patients responsibility and payment is expected at the time of service unless other arrangements have been made.

Siganture_____ Date_____

CHILDS INFORMATION

Tell us about your child

Today's Date_____ Childs Name_____ M ☐ F ☐
Any Nickname or preferred name?_____ Childs Birth date: _____/_____/_____
Age: _____
Childs Home #_____
Childs Home Address _____

Who Is Accompanying The Child Today

Name_____ Relation _____
Do you have legal custody of this child? Y☐ N☐
Whom may we thank for referring you? _____
Other family member seen by us? _____ _____
Last dental visit date _____
Parents Marital Status (check the box to the right of your selection):
Married ☐ **Widowed** ☐ **Partnered** ☐ **Single** ☐ **Divorced** ☐ **Seperated** ☐

Mothers Information

Name _____ Birthdate _____
Home #_____ Cell #_____ Work #_____
Employer _____ Email Address _____
SS# _____

Fathers Information

Name_____ Birthdate _____
Home #_____ Cell #_____ Work #_____
Employer _____ Email Address _____
SS# _____

Person Responsible for Account

Name_____ Relation_____
Billing Address _____
Phone #_____ Cell #_____ Employer_____
Work Phone #
Best Phone # to reach
Who is Responsible for making the Appointments
What is the best way to confirm appointments and to contact you? ☐ Email ☐ Phone ☐ Text message

Insurance Coverage for your Child

Do you have the benefit of any dental coverage?

Primary Insurance

Insured Name_____ Group #_____
Company Name_____ Relation_____

Insured Birthdate _____/_____/_____
Insured ID # _____ Insured Employer_____
Orthodontic Coverage? Y ☐ N ☐

Secondary Insurance

Insured Name_____ Group #_____
Company Name_____
Relation_____
Insured Birthdate _____/_____/_____
Insured ID # _____ Insured Employer_____
Orthodontic Coverage? Y ☐ N ☐

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Although payment is due at the time of service, occasionally arrangements are made which involve the carrying of a balance over a period of months with Keating Family Dental, PLLC. I acknowledge that by carrying a balance with Keating Family Dental, PLLC I am receiving an extension of credit from Keating Family Dental , PLLC. This credit is subject to interest rates in accordance with the laws of the State of New York. I acknowledge that Keating Family Dental, PLLC may charge interest on my balance up to the maximum allowed by the State of New York.

Financial Information

We will gladly assist you in processing your dental claims and pre-estimates with your insurance company. Please keep in mind that dental insurance is a benefit to help with the cost of dental treatment. We have several ways to help you achieve the maximum dental health that you want. There are several outside finance companies that we work with to be able to make treatment fit your budget. Our team is knowledgeable in being able to assist you in working through the financial end of dental treatment.

Signature_____ Date_____