PATIENT INFORMATION (CONFIDENTIAL) Date:_____

Name_____
(FIRST) (MI) (LAST)
Birth date _____ SS/SIN#_____ Email_____
Address_____City_____State____Zip_____
Home Ph_____ Work Ph_____ Cell Ph_____
Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If College Student, FT/PT School Name_____ City/State_____
Employer_____Address_____
Whom may we thank for referring you? _____
Person to contact; in case of an emergency_____
(Name) (Phone)

RESPONSIBLE PARTY (Parent/Guardian) ☐ Check this box if same as patient.

Name _____Relationship to Patient_____

_____
(Address) (City) (State) (Zip)

Birth date _____ SS/SIN# _____ Primary Ph# _____

INSURANCE INFORMATION ☐ Check box if same as Patient
☐ Check box if same as Responsible Party

Name of Insured_____ Relationship to Patient_____
Birth date_____ SS#/SIN_____ Work Number_____
Employer_____ Union or Local #_____
Employers Address_____
Insurance Co._____ Ph Number_____
Ins. Address_____
Policy#/Member ID_____ Group Number_____

Do you have any secondary Insurance? ____ If yes, Please complete the following:

Name of Insured_____ Relationship to Patient_____
Birth date_____ SS#/SIN_____ Work Number_____
Employer_____ Union or Local #_____
Employers Address_____
Insurance Co._____ Ph Number_____
Ins. Address_____
Policy#/Member ID_____ Group Number_____

Church Street Dental
Walter E. Gazda, D.M.D., P.C.
109 Church Street
Chicopee, MA 01020
Telephone: (413) 592-2342

Fluoride benefits people of all ages

The American Dental Association (ADA) and American Medical Association (AMA) highly recommend fluoride for people with any of the following:

History of reoccurring decay
Areas of recession
Areas of sensitivity
Dry mouth
Patients receiving radiation therapy
Poor diet
Crowns or bridges

The fee for all fluoride treatments is $31.00. Children are usually covered BUT Insurance companies do not always guarantee reimbursement.

____ Yes. I want to receive fluoride treatments and I understand whether or not my insurance reimburses me, that I am responsible for payment in full.

____ No. I do not want to receive fluoride treatments and I understand the health benefits that I am refusing.

Signature:_____ Date:_____

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Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

Insurance Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Gazda 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 doctor may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP ☐ Heart Rate: ☐

Height: ☐
Weight: ☐

Y N	Conditions
☐ ☐	Acid Reflux Or G.E.R.D.
☐ ☐	Alcohol Abuse Or Drug Abuse
☐ ☐	Allergies
☐ ☐	Alzheimer's
☐ ☐	Anemia
☐ ☐	Angina Pectoris
☐ ☐	Arthritis Or Rheumatism
☐ ☐	Artificial Bones
☐ ☐	Artificial Heart Valve
☐ ☐	Asthma
☐ ☐	Blood Transfusion
☐ ☐	Bruise Easily Or Bleed Easily
☐ ☐	Cancer
☐ ☐	Cancer Drugs W/ Bisphosphonates
☐ ☐	Congenital Heart Defect
☐ ☐	Diabetes
☐ ☐	Difficulty Breathing
☐ ☐	Eating Disorders
☐ ☐	Emphysema
☐ ☐	Epilepsy
☐ ☐	Fainting Spells Or Dizzy Spells
☐ ☐	Fever Blisters

Y N	Conditions
☐ ☐	HIV+ AIDS
☐ ☐	Heart Attack Or Heart Disease
☐ ☐	Heart Murmur/Mitral Valve Prolapse
☐ ☐	Heart Surgery
☐ ☐	Hemophilia
☐ ☐	Hepatitis A, B, Or C
☐ ☐	High Blood Pressure
☐ ☐	High Cholesterol
☐ ☐	Kidney Problems
☐ ☐	Liver Disease Or Yellow Jaundice
☐ ☐	Low Blood Pressure
☐ ☐	Lung Problem
☐ ☐	Nervousness/Anxiety
☐ ☐	Pace Maker
☐ ☐	Prolonged Or Abnormal Bleeding
☐ ☐	Psychiatric Problems
☐ ☐	Radiation Therapy
☐ ☐	Rheumatic Fever
☐ ☐	Seizures
☐ ☐	Sexually Transmitted Disease
☐ ☐	Sinus Problems
☐ ☐	Stroke

Y N	Conditions
☐ ☐	Surgery
☐ ☐	Taking Blood Thinners
☐ ☐	Thyroid Problems
☐ ☐	Tuberculosis
☐ ☐	Ulcers
☐ ☐	Wear Contact Lenses

Y N	Allergies
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Erythromycin
☐ ☐	Jewelry
☐ ☐	Latex
☐ ☐	Metals
☐ ☐	Penicillin
☐ ☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above?**
If yes, please describe below...

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

Patient's Dental History

Name (Print):_____

Category: Dental History

1. When was your last dental visit? Name and location of previous dentist?

2. Have you had a complete series of dental films (x-rays)? Taken when?

3. If you could change ANYTHING about your smile, what would it be?

4. Have you ever experienced any of the following problems in your jaw?
Choose ALL THAT APPLY:

__ Clicking
__ Difficulty in opening or closing
__ Difficulty in chewing
__ None
__ Pain (joint, ear, side of face)

5. Do you wear or have ever worn... If yes, date of placement.
Choose ALL THAT APPLY:

__ Dentures
__ Other appliance
__ Bite Plate/Night Guard
__ None
__ Partials

6. Have you experienced any of the following...?
Choose ALL THAT APPLY:

__ Head Injuries
__ Sores/lumps near/in your mouth
__ Pain in any teeth
__ Loosening of your teeth
__ Bleeding gums when brushing
__ Clenching or grinding
__ Neck Injuries
__ Frequent Headaches
__ Bleeding gums when flossing
__ Frequently bite your lips/cheeks
__ Jaw Injuries
__ None

7. Are your teeth sensitive to hold or cold?

__ YES __ NO

8. Does food tend to become caught between your teeth?

__ YES __ NO

9. Have you ever had any Orthodontic treatment?

__ YES __ NO

10. Have you ever had periodontal treatment? (gums)

__ YES __ NO

11. Have you ever had any difficult extractions or prolonged bleeding?

__ YES __ NO

Signature:_____ **Date:**_____

Church Street Dental
109 Church St Chicopee MA 01020
413-592-2342
www.churchstreetdental.com

Notice of Privacy Practices HIPAA

I have received a copy of the HIPAA notification.

Signature Date

My information can be shared with:

Name Relation to patient