MARIA CHILA, DMD
Patient Information

Patient Name: ______________________________ Preferred Name ____________________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other____________________

Birth Date:______________Social Security #: ______________________

Phone (Home): __________ (Work):__________ Ext:____ (Cell):__________ (Email):________________

Preferred contact method for appointment confirmation: (Circle 1): Home Work Cell

Address: ____
Street Apartment #

____
City State Zip Code

Referral Information

Who may we thank for referring you to our practice? ☐ Friend ☐ Relative

Name of person or office referring you to our practice:__________________________________

☐ Dental Office ☐ Work ☐ Internet ☐ Other____________________

Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ______________________________ Birth Date: ______________________

Phone (Home): ______________(Work): ______________ Ext:_______ Best time to call: ________

Address: ____
Street Apartment #

____
City State Zip Code

Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ________________ Group #:______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other________________

Insurance Plan Name and Address: ______________________________________

____

Secondary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ________________ Group #:______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other______________________

Insurance Plan Name and Address: _

MARIA CHILA, DMD
Medical History

Are you in good health? Yes No

Physician's Name: ______________________________Address:__________________________
Phone Number: ___________________________Pharmacy Phone Number___________________
Are you now under the care of a physician? Yes No
Have you had a serious illness or operation or been hospitalized in the past five years? Yes No
Do you use tobacco? Yes No

Have you ever been diagnosed with any of the following?

- ☐ Heart murmur
- ☐ Mitral valve prolapse
- ☐ Artificial heart valves
- ☐ Rheumatic fever
- ☐ Cardiovascular disease
- ☐ Angina
- ☐ Arteriosclerosis
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Damaged heart valves
- ☐ Heart attack
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Congenital heart defects
- ☐ Pacemaker
- ☐ Rheumatic heart disease
- ☐ Abnormal bleeding
- ☐ Anemia
- ☐ Blood transfusion

If yes, date:_________

- ☐ Hemophilia
- ☐ AIDS or HIV infection
- ☐ Arthritis
- ☐ Autoimmune disease
- ☐ Rheumatoid arthritis
- ☐ Systemic lupus erythematosus
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Sinus trouble
- ☐ Tuberculosis
- ☐ Cancer/ Chemotherapy/ Radiation treatment
- ☐ Chest pain upon exertion
- ☐ Chronic pain
- ☐ Diabetes Type I or II
- ☐ Eating disorder
- ☐ Malnutrition
- ☐ Gastrointestinal disease
- ☐ G.E. Reflux/ Persistent heartburn
- ☐ Ulcers
- ☐ Thyroid problems
- ☐ Glaucoma
- ☐ Hepatitis jaundice or liver disease
- ☐ Stroke
- ☐ Epilepsy
- ☐ Fainting spells or seizures
- ☐ Neurological disorders

If yes, specify: ____________

- ☐ Sleep disorder
- ☐ Snoring
- ☐ Mental health disorders

If yes, specify: _____________

- ☐ Recurrent infections

Type of infection: ____________

- ☐ Kidney problems
- ☐ Night sweats
- ☐ Osteoporosis
- ☐ Persistent swollen glands in neck
- ☐ Severe headaches/ Migraines
- ☐ Severe or rapid weight loss
- ☐ Sexually transmitted disease
- ☐ Excessive urination

Allergies: Are you allergic to, or have you had a reaction to:

- ☐ Local anesthetics___________________________________
- ☐ Aspirin____
- ☐ Penicillin or other antibiotics___________________________
- ☐ Barbiturates, sedatives, or sleeping pills________________
- ☐ Sulfa drug____
- ☐ Codeine or other narcotics___________________________
- ☐ Metals____
- ☐ Latex____
- ☐ Iodine____
- ☐ Hay fever/ seasonal ________________________________
- ☐ Animals ____
- ☐ Food____
- ☐ Other____

Joint Replacement: Have you had an orthopedic total joint replacement?
Date: _____________ Have you had any complications? Please explain: ______________________________
☐Hip ☐Knee ☐ Shoulder
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No

Women Only Are you:

- ☐ Pregnant
- ☐ Taking birth control pills
- ☐ Taking hormone replacement therapy
- ☐ Nursing

Is there anything else our office should know about your medical history prior to dental treatment? If yes please explain:
____
____

Please list all the medications you are taking including prescription and/or over the counter medicines:

Medication	Dosage	For what reason
____________________	________________	_________________
____________________	________________	_________________
____________________	________________	_________________
____________________	________________	_________________

To the best of my knowledge the above information is accurate.

_______________________ Patient's signature   _______________ Date   ____________________ Doctor's signature

MARIA CHILA, DMD

Dental Health Questionnaire

Who was your previous dentist?____

Were you satisfied with your dental care?____

Reason for your dental visit? ____

Date of last dental visit? ____________________

Have you ever had a serious injury to your head or mouth? Yes No

Check any of the following below if they are a problem for you:

- ☐ Bleeding gums
- ☐ Cold sensitivity
- ☐ Hot sensitivity
- ☐ Sweet sensitivity
- ☐ Pressure sensitivity
- ☐ Toothache
- ☐ Loose teeth
- ☐ Swollen gums
- ☐ Mouth sores
- ☐ Teeth grinding
- ☐ Bad breath
- ☐ Food getting caught between teeth
- ☐ Jaw pain (clicking, popping)
- ☐ Jaw locking (open, close)
- ☐ Soreness in facial muscles

Are you happy with your smile? Yes No

Are there any cosmetic changes that you would like to discuss?

- ☐Replacing missing teeth
- ☐Teeth lightening
- ☐Straightening your teeth
- ☐Replacing silver fillings with tooth colored fillings

How important is it to keep your natural teeth?

- ☐Very important
- ☐Somewhat important
- ☐Not important