



HEARTHSTONE

FAMILY DENTAL

435 Limekiln Drive, Chambersburg, Pennsylvania 17201

Phone 717.267.3922 Fax 717.267.3202

Welcome To Our Office

Our goal is to provide you comfortable, comprehensive and convenient dental care. We will ensure you have every question answered regarding your dental treatment. We constantly strive to improve all aspects of care that we provide to you. If you are ever concerned with the care you are receiving, please contact us so we may achieve our goals for you.

Patient Information

Name Mr. Mrs. Ms. _____
First MI Last Preferred Name

Marital Status Single Married Divorced Widowed

Street Address _____

City _____ State _____ Zip _____

Phone # Home _____ Cell _____ Work _____

(Please indicate preferred phone number to contact first)

E-mail address _____

Social Security Number _____ Date of Birth _____ Age _____

How would you like us to confirm your appointments? (select as many as you would like)

Mail E-mail Phone (home work cell) Text

Whom may we contact in case of emergency? _____ Phone _____

Whom may we thank for referring you? _____ Phone _____

Do you have dental insurance? Yes No **(if yes, please fill out below information)**

Primary Insurance

Secondary Insurance

Subscriber Name _____

Subscriber Name _____

SSN _____ DOB _____

SSN _____ DOB _____

(If different from patient information)

(If different from patient information)

Relationship to Patient _____

Relationship to Patient _____

Employer _____

Employer _____

Occupation _____

Occupation _____

Insurance Company _____

Insurance Company _____

Group Number _____

Group Number _____

Member ID Number _____

Member ID Number _____

Medical History

(FRONT AND BACK)

General Health: (check box) Excellent Good Fair Date of last physical _____

Physician's Name _____ Phone _____

Answers to the following are for our records and remain confidential.

Are you under current medical treatment? Yes No

If yes, please explain: _____

Are you currently taking any medication or herbal supplements? Yes No

If yes, please list all prescription and non-prescription medications, including vitamins and supplements on medication log (see reverse page).

Do you have allergies or adverse reaction to drugs? Yes No

If yes, please list drug and reaction: _____

Have you ever taken I.V. or oral Bisphosphonates for bone density such as Fosamax, Actonel, Boniva, Aredia, Zometa or Bonefos? Yes No

Are you on a special diet? Yes No

Have you lost or gained more than 10 pounds in the past year? Yes No

Do you use any form of tobacco? Yes No

What Type (please circle) Cigarettes Cigars Snuff Chew How much? _____

Are you interested in quitting? Yes No

Do you consume alcohol? Yes No If yes, how much per week on average? _____

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

Heart Disease Yes No

Pacemaker Yes No

High Blood Pressure Yes No

Stroke Yes No

Artificial Heart Valve Yes No

Other Heart Ailment Yes No

Cancer Yes No

Chemo/Radiation Therapy Yes No

Major Operations Yes No

Arthritis Yes No

Artificial Joints Yes No

Liver Disease Yes No

Hepatitis Yes No

Kidney Disease Yes No

Diabetes Yes No

Family History Diabetes Yes No

Intestinal Disease Yes No

Gastric Reflux Yes No

Respiratory Disease Yes No

Asthma Yes No

Sleep Apnea Yes No

Bleeding Problems Yes No

Latex Sensitivity Yes No

Organ Transplant Yes No

Caffeine Dependency Yes No

Alcohol Dependency Yes No

HIV or AIDS Yes No

Psychologic/Psychiatric Treatment Yes No

Do you have a disease or condition not listed Yes No

If yes, please explain:

Women, are you: (please circle) Pregnant Nursing On Hormone Therapy Taking Birth Control

Dental History

(FRONT AND BACK)

What is your immediate dental concern or like us to address today?

Do you have dental pain now? _____

Previous dentist name: _____ Previous dentist location: _____

When was your last dental visit? _____

What was done at that appointment? _____

- | | | | |
|--|--------------------------|---|--------------------------|
| Unfavorable dental experiences | <input type="checkbox"/> | Jaw Problems (TMJ) | <input type="checkbox"/> |
| Dental fears | <input type="checkbox"/> | Difficulty opening your mouth widely | <input type="checkbox"/> |
| Preference for no dental anesthetic | <input type="checkbox"/> | Stiff or sore head, neck or shoulder muscles | <input type="checkbox"/> |
| Problems with effectiveness of or bad reactions to dental anesthetic | <input type="checkbox"/> | Do you wake up with tooth or jaw pain? | <input type="checkbox"/> |
| Orthodontic treatment (braces)
When _____ | <input type="checkbox"/> | Tension headaches | <input type="checkbox"/> |
| Bleeding gums | <input type="checkbox"/> | Clench or grind your teeth | <input type="checkbox"/> |
| Habitual chewing of hard substances
i.e. ice, popcorn kernels | <input type="checkbox"/> | Jaw clicking or popping | <input type="checkbox"/> |
| Part of your mouth sensitive to temperature | <input type="checkbox"/> | Any oral appliances | <input type="checkbox"/> |
| Lumps or bumps on head or neck | <input type="checkbox"/> | Any removable teeth | <input type="checkbox"/> |
| Dry mouth | <input type="checkbox"/> | Family history of diabetes | <input type="checkbox"/> |
| Do you have a sugar or soda pop habit | <input type="checkbox"/> | Parents who have lost teeth or had gum disease | <input type="checkbox"/> |
| Unpleasant taste or odor in your mouth | <input type="checkbox"/> | Noticed loose teeth or a change in your bite | <input type="checkbox"/> |
| Viral infection or cold sores | <input type="checkbox"/> | Breath through your mouth while awake or sleep? | <input type="checkbox"/> |

How often do you brush? _____ Floss? _____

Other oral health aids: _____

Dental History Continued...

When it comes to your oral health, do you prefer to be Proactive? Someone who likes to avoid complications. Who'd rather take care of an issue today instead of letting it worsen over time which might cost more time, visits, money and/or pain to fix down the road?

Yes No

What do you value most in a dental office? Please write answer below.

Cosmetic– You most value how your teeth look (straight, white, etc.)

Function– You most value an ability to enjoy your favorite foods & drinks. You do not want to be limited to eating on one side/area.

Comfort– You most value NOT being in pain or having any tooth or gum sensitivities.

Example: I can't eat this anymore because it hurts or is sensitive

Longevity– You most value the ability to have your natural teeth forever. You expect the treatment you have completed to last forever.

What is the most important objection/obstacle you have to visiting a dental office? Please write answer below.

No objections or obstacles– Schedule and keep routine visits every 6 months as recommended. No dental fears or concerns with attending dental appointments.

Time– Having appointment times that suite your schedule with work and day to day activities.

Budget– Not having the finances to invest in dental treatment.

Lack of Trust– Unfavorable past dental experiences.

Lack of Urgency– Nothing has caused pain or discomfort so there has not been a reason to see a dentist.

How important is it for you to keep your teeth for the rest of your life? (circle one)

Not important 1 2 3 4 5 6 7 8 9 10 Very Important

How do you rank your smile? (circle one)

Unpleasant 1 2 3 4 5 6 7 8 9 10 Beautiful

What would you change about your smile or bite if you could? _____