WEST CHESTER Family & Cosmetic Dentistry

Welcome! *We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.*

Patient Information

Name _____ Social Security # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑M ❑F Age ____ Birth Date ___ / ___ / ___ ❑Single ❑Married ❑Widowed ❑Seperated ❑Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birth Date ____ / ____ / ____ Social Security # _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependants under this plan _____

Additional Insurance

Is patient covered by additional insurance? ❑Yes ❑No

Subscriber Name _____ Relation to Patient _____ Birth Date ____/ ____ / ____

Address (if different from patient) _____

City _____ State _____ Zip _____ Home Phone

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependants under this plan _____

Dental History

What would you like us to do today? _____ Are you in dental discomfort? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) Yes or No if you have had problems with any of the following:

❑Y ❑N Bad breath
❑Y ❑N Bleeding gums
❑Y ❑N Clicking or popping jaw
❑Y ❑N Food collection between teeth
❑Y ❑N Grinding or clenching teeth
❑Y ❑N Loose teeth or broken fillings
❑Y ❑N Gum disease
❑Y ❑N Sensitivity to cold
❑Y ❑N Sensitivity to hot
❑Y ❑N Sensitivity to sweets
❑Y ❑N Sensitivity when biting
❑Y ❑N Sores or growths in mouth

How often do you brush? _____ Floss? _____

Is there anything about the appearance of your teeth that you would like to change? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑Y ❑N

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illness or operations? ❑Y ❑N

If yes, describe _____

Are you currently under physician care? ❑Y ❑N If yes, describe _____

Have you ever had a blood transfusion? ❑Y ❑N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? ❑Y ❑N

Have you ever used a bisphosphonate? Brand names include Fosamax, Actonel, Atelvia, Didronel & Boniva. ❑Y ❑N

Women: Are you pregnant? ❑Y ❑N Nursing? ❑Y ❑N Taking birth control pills? ❑Y ❑N

Check (✓) Yes or No if you have had problems with any of the following:

❑Y ❑N AIDS/HIV Positive
❑Y ❑N Anaphylaxis
❑Y ❑N Anemia
❑Y ❑N Arthritis, Rheumatism
❑Y ❑N Artificial heart valves
❑Y ❑N Artificial joints
❑Y ❑N Asthma
❑Y ❑N Atopic (allergy prone)
❑Y ❑N Back problems
❑Y ❑N Blood disease
❑Y ❑N Cancer
❑Y ❑N Chemical dependency
❑Y ❑N Chemotherapy
❑Y ❑N Circulatory problems
❑Y ❑N Cortisone treatments
❑Y ❑N High blood pressure
❑Y ❑N Cough, persistent
❑Y ❑N Cough up blood
❑Y ❑N Diabetes
❑Y ❑N Epilepsy
❑Y ❑N Fainting
❑Y ❑N Food allergies
❑Y ❑N Glaucoma
❑Y ❑N Headaches
❑Y ❑N Heart Murmur
❑Y ❑N Heart problems
Describe _____
❑Y ❑N Hemophilia/ Abnormal bleeding
❑Y ❑N Herpes
❑Y ❑N Hepatitis
❑Y ❑N Rheumatic/Scarlet fever
❑Y ❑N Jaw pain
❑Y ❑N Kidney disease or Malfunction
❑Y ❑N Liver Disease
❑Y ❑N Material allergies (latex, wool, metal, chemicals)
❑Y ❑N Mitral valve prolapse
❑Y ❑N Nervous problem
❑Y ❑N Pacemaker/ Heart Surgery
❑Y ❑N Psychiatric care
❑Y ❑N Rapid weight gain/loss
❑Y ❑N Radiation treatment
❑Y ❑N Respiratory disease
❑Y ❑N Shingles
❑Y ❑N Shortness of breath
❑Y ❑N Skin rash
❑Y ❑N Spina Bifida
❑Y ❑N Stroke
❑Y ❑N Surgical implant
❑Y ❑N Swelling of feet or ankles
❑Y ❑N Thyroid disease or malfunction
❑Y ❑N Tobacco habit
❑Y ❑N Tonsillitis
❑Y ❑N Tuberculosis
❑Y ❑N Ulcer/Colitis
❑Y ❑N Venereal disease

Is patient currently taking any medications? If yes, list all: _____

Does patient have drug allergies? If yes, list all: _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing incorrect information can be dangerous to my health. I authorize and request my insurance company to pay directly to Dr. M. Sanjeevan all applicable insurance benefits. I understand that my dental insurance is a contract between the insurance carrier and me, and not between Dr. M. Sanjeevan and me. I am ultimately financially responsible for all dental fees the above named patient or I incur during the course of treatment with Dr. M. Sanjeevan*. I further hereby acknowledge and agree that at least 24 hours notice is required to cancel an appointment without incurring broken appointment charges. I also grant permission to be called concerning my account and appointments. I authorize the release of my, and/or the above named patients records to a third party.

✗ Signature _____ (or Guardian if patient is a minor) Date ___/___/___

**For your convenience we accept cash, Visa, MasterCard and Discover*