CORNWALL DENTAL ARTS
FAMILY AND COSMETIC DENTISTRY
DR. STEVEN J. DENEKA

Welcome to our Practice!

Will you please help us by providing us with the following confidential information?

PATIENT INFORMATION:

Last Name: _____ First Name: _____Preferred Name: _____

Street Address: _____ City, Province, Postal Code: _____

Date of Birth:_____ Email Address: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Sex: Male_____ Female_____ Occupation: _____

Employer: _____ Address:_____

Emergency Contact Name: _____ Phone #: _____

Spouse's Name: _____ Phone Number: _____

In the event that we must contact you for scheduling changes, etc, please indicate the BEST PHONE NUMBER during business hours to phone you:

Phone number: _____

How did you hear about our office? Please check: _____Internet ____Patient referral ____Website ____Yellow Pages ___Mailer Other_____

If you were referred, whom may we thank for their trust in us? _____

INSURANCE INFORMATION: (YES_____ NONE_____)

Primary Insurance Company: _____ Group# or Policy#: _____

Policy Holder Name: _____Member's ID#: _____ Birth date: _____

Secondary Insurance Company: _____ Group# or Policy#: _____

Policy Holder Name: _____Member's ID#: _____ Birth date: _____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. I understand that my dental insurance is a contract between me and my insurance carrier and not **between Dr. Steven Deneka Dentistry Professional Corporation and my insurance company.**
All professional services are charged directly to the patient and patients are personally responsible for payment of their accounts. We will prepare any necessary forms or reports to help you collect your benefits from your insurance company.

Date:_____ Patient's Signature _____

CONSENT:

I hereby authorize Dr. Steven Deneka Dentistry Professional Corporation to take the necessary X-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my/ the patient's dental needs. I also authorize Dr. Steven Deneka Dentistry Professional Corporation to perform all forms of treatment, medication and therapy that is agreed to be necessary or advisable. I also understand the use of anesthetic agents embodies a certain risk.

I fully understand that it is my financial responsibility for all dental treatment provided, regardless of insurance coverage, and understand that complete payment will be made after each treatment. We accept cash, Debit, Visa, and MasterCard.

Appointment times are reserved for you and we require 48 hours notice (2 business days) notice if you are required to change an appointment. A fee may be charged for cancelled or missed appointments without sufficient notice.

Patient Signature: _____ Date: _____ Dr. Signature: _____

MEDICAL HEALTH HISTORY **PATIENT NAME: _____ Date: _____**

Name of your family physician: _____ Date of last Medical Exam: _____

Address of physician: _____ Phone Number: _____

A. **CIRCLE YOUR ANSWERS** (leave BLANK if you do not understand the question):

1. Yes No Are you in good health?

2. Yes No Has there been a change in your health within the last year? Explain: _____

3. Yes No Have you been hospitalized or had a serious illness in the last 5 years? Explain: _____

_____

4. Yes No Are you being treated by a physician now? Reason: _____

Name of additional physician(s): _____

B. HAVE YOU EVER EXPERIENCED?

5. Yes No Chest Pains
6. Yes No Swollen Ankles
7. Yes No Shortness of breath
8. Yes No Recent weight loss, fever, night sweats
9. Yes No Persistent cough, coughing up blood
10. Yes No Bleeding problems, bruising easily
11. Yes No Sinus Problems
12. Yes No Difficulty swallowing
13. Yes No Joint pain, stiffness
14. Yes No Jaundice
15. Yes No Dizziness
16. Yes No Ringing in ears
17. Yes No Frequent Headaches
18. Yes No Fainting spells
19. Yes No Blurred Vision
20. Yes No Seizures/ Epilepsy
21. Yes No Excessive thirst
22. Yes No Frequent urination
23. Yes No Dry Mouth
24. Yes No Sleep apnea or chronic snoring

C. DO YOU HAVE OR HAVE YOU HAD?

25. Yes No Heart disease
26. Yes No Heart attack, heart defects
27. Yes No Heart murmur
28. Yes No Rheumatic fever
29. Yes No Mitral Valve Prolapse
30. Yes No High Blood Pressure/ Low Blood pressure
31. Yes No Stroke, hardening of arteries
32. Yes No Hepatitis, A B C
33. Yes No Stomach problems, ulcers
34. Yes No Diabetes (Type I or Type II)
35. Yes No TB, Emphysema, or other lung diseases
36. Yes No HIV positive or AIDS-ARC
37. Yes No Tumors, Cancer
38. Yes No Arthritis, rheumatism
39. Yes No Eye disease/ Glaucoma
40. Yes No Skin disease
41. Yes No Anemia or other blood disorders
42. Yes No STI
43. Yes No Hormone Deficiency
44. Yes No Kidney, bladder diseases
45. Yes No Thyroid, adrenal diseases
46. Yes No Liver Disease

D. DO YOU HAVE OR HAVE YOU HAD?

47. Yes No Surgeries
48. Yes No Blood Transfusions
49. Yes No Artificial Joint
50. Yes No Contact Lenses
51. Yes No Psychiatric Care
52. Yes No Radiation Treatments
53. Yes No Chemotherapy
54. Yes No Prosthetic heart valve
55. Yes No Pacemaker
56. Yes No Currently taking Birth Control Pills
57. Yes No Currently Pregnant or nursing

E. DO YOU TAKE OR HAVE TAKEN?

58. Yes No Recreational drugs
59. Yes No Alcohol
60. Yes No Tobacco in any forms (Smoke or Chew)
61. Yes No Fen Phen diet Pills or any other diet pills
62. Yes No Fosamax/Boniva or other Bisphosphonate drugs (Osteoporosis)
63. Yes No Trouble getting numb or adverse reaction to local anesthetic

F. ALLERGIES: (LATEX,DRUGS,MEDICATIONS,ETC)

_____

_____

_____

Patient initials: _____

G. MEDICATIONS OR VITAMINS: _____

_____

_____

_____

_____

_____

64. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

_____

_____

_____

65. Yes No Have you ever been told by a physician or dentist that you need to be pre-medicated with antibiotics prior to any dental treatment?

_____

_____

Name of your Former Dentist: _____

How long since you were last seen? _____

Patient Signature: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____

BITE AND JAW JOINT:

66. Yes No Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)
67. Yes No Do you feel like your lower jaw is being pushed back when you bite your teeth together?
68. Yes No Do you avoid or have difficulty chewing hard dry foods? (e.g. gum, carrots, nuts, bagels, baguettes)
69. Yes No Have your teeth changed in the last 5 years, become shorter, thinner, or worn?
70. Yes No Are your teeth crowding or developing spaces?
71. Yes No Do you have more than one bite and squeeze to make your teeth fit together?
72. Yes No Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?
73. Yes No Do you clench your teeth in the daytime or make them sore?
74. Yes No Do you have any problems with sleep or wake up with an awareness of your teeth?
75. Yes No Do you wear or have your ever worn a bite appliance? (Night Guard, NTI, TMJ appliance)

DENTAL HEALTH HISTORY

76. Is keeping your teeth important to you? Yes No If yes, why? _____
77. On a scale of 1-10, 10 being the best, where would you rate your smile?_____
78. On a scale of 1-10, 10 being the best, where you rate your oral health?_____
79. Have you experienced any of the following?:

Yes No Bleeding gums	Yes No Sensitivity to Hot & Cold
Yes No Bad Breath or sour taste in mouth	Yes No Food catching between teeth
Yes No Clenching or grinding of teeth	Yes No Oral Surgery of any kind?
Yes No Pain/soreness around ears, eyes, face	Yes No Did you ever wear braces?
Yes No Have you or your parents suffer(ed) from Gum Disease?	Yes No Ever been injured in your mouth or head?
Yes No Do you or your parents wear dentures/partials?	Yes No Burning sensations in mouth
Yes No Endodontic Treatment (Root Canal)	Yes No Bad dental Experience

80. Does having dental treatment make you afraid or nervous? Yes No If yes, what specific things bother you? _____

_____

81. Is the brightness of your teeth important to you? Yes No

82. If you could change anything about your smile which of the following would you want?

Yes No Whiter	Yes No Close space or spaces	Yes No Replace chipped teeth
Yes No Replace missing teeth	Yes No Replace old crowns	Yes No Remove silver fillings
Yes No Remove Stains/Spots on teeth	Yes No Excess showing of Teeth	Yes No Replace old plastic filling(s)
Yes No Straighter	Yes No Less Gum showing	Yes No Reshape/resize my teeth

83. **Please circle the following which are important to you when making your dental health decision.**

Convenience	Appearance	Relationship with Dental Team
Finances	Time	Quality of care
What insurance covers	Health	Detailed treatment explanations
Comfort	Technology	

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____