

We'd like to get to know you better...



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Please complete this form and bring it with you to your appointment.

## Patient Information (CONFIDENTIAL)

Patient # \_\_\_\_\_

SS# / SIN \_\_\_\_\_

Date: \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Check Appropriate Box:    Minor    Single    Married    Divorced    Widowed    Separated

If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time \_\_\_\_\_

Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Spouse or Parent/Guardian's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

**All appointments will be confirmed 24 hours prior. Please circle the phone # you prefer for confirming appointments**

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Birthdate \_\_\_\_\_

Relationship to Person \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS#/SIN \_\_\_\_\_

Is this Person currently a Patient in our Office?    Yes    No

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Home Phone \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

How Much is your Deductible? \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

**DO YOU HAVE ANY ADDITIONAL INSURANCE    Yes    No    If Yes, complete the following:**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Home Phone \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

How Much is your Deductible? \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

*Over Please*

# Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Are you under medical treatment now? Yes No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?  
If yes, please explain \_\_\_\_\_
3. Are you taking any medication(s) including non-prescription medicine?  
If yes, please explain \_\_\_\_\_
4. Have you ever taken Fen-Phen/Redux?
5. Do you use tobacco?
6. Do you use controlled substances?
7. Are you wearing contact lenses?
8. Do you have or have you had any of the following?  
Yes No
- |                        |                                 |                       |
|------------------------|---------------------------------|-----------------------|
| High Blood Pressure    | Heart Disease                   | Chest Pains           |
| Heart Attack           | Cardiac Pacemaker               | Easily Winded         |
| Rheumatic Fever        | Heart Murmur                    | Stroke                |
| Swollen Ankles         | Angina                          | Hay Fever / Allergies |
| Fainting / Seizures    | Frequently Tired                | Tuberculosis          |
| Asthma                 | Anemia                          | Radiation Therapy     |
| Low Blood Pressure     | Emphysema                       | Glaucoma              |
| Epilepsy / Convulsions | Cancer                          | Recent Weight Loss    |
| Leukemia               | Arthritis                       | Liver Disease         |
| Diabetes               | Joint Replacement or transplant | Heart Trouble         |
| Kidney Diseases        | Hepatitis / Jaundice            | Respiratory Problems  |
| AIDS or HIV Infection  | Sexually Transmitted Disease    | Mitral Valve Prolapse |
| Thyroid Problem        | Stomach Troubles / Ulcers       | Other                 |
9. Are you allergic to or have you had any reactions to the following?  
Yes No
- Local Anesthetics (e.g. Novocain)  
Penicillin or any other Antibiotics  
Sulfa Drugs  
Barbiturates  
Sedatives  
Iodine  
Aspirin  
Any Metals (e.g. nickel, mercury, etc.)  
Latex Rubber  
Other (please list)
10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)
11. Women Only:  
a) Are you pregnant or think you may be pregnant?  
b) Are you nursing?  
c) Are you taking oral contraceptives?  
Yes No Yes No

# Patient Dental History

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Do your gums bleed while brushing or flossing? Yes No
2. Are your teeth sensitive to hot or cold liquids/foods?
3. Are your teeth sensitive to sweet or sour liquids/foods?
4. Do you feel pain to any of your teeth?
5. Do you have any sores or lumps in or near your mouth?
6. Have you had any head, neck or jaw injuries?
7. Have you ever experienced any of the following problems in your jaw?  
Clicking  
Pain (joint, ear, side of face)  
Difficulty in opening or closing  
Difficulty in chewing
8. Do you have frequent headaches?
9. Do you clench or grind your teeth?
10. Do you bite your lips or cheeks frequently?
11. Have you ever had any difficult extractions in the past?
12. Have you ever had any prolonged bleeding following extractions?
13. Have you had any orthodontic treatments?
14. Do you wear dentures or partials?  
If yes, date of placement \_\_\_\_\_
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?
16. Do you like your smile?
17. Do you snore or have sleep apnea? Yes No

# Authorization and Release

*I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.*

X

Signature of patient (or parent/guardian if minor)

Doctor's Comments \_\_\_\_\_

Signature \_\_\_\_\_