

WELCOME TO SUFFIELD VILLAGE DENTAL

PATIENT INFORMATION (Confidential)

Date _____

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

SS # _____ Date of Birth _____

Check Appropriate Box: Minor Single Married Divorced Widowed

Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____

Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

RESPONSIBLE PARTY (If Different from above)

Name of Person Responsible for this account _____ Relationship to Pt _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone _____ SS # _____

For your convenience, we offer the following methods of payment. Pay in full at each visit.

Cash Visa MasterCard Amex Discover Personal Check Dental Fee Plan

INSURANCE INFORMATION

Name of Insured _____ Relationship to Pt _____

Birth date _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

IF YOU HAVE ANY ADDITIONAL DENTAL INSURANCE, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Pt _____

Birth date _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

OVER PLEASE

PATIENT MEDICAL HISTORY

Physician _____	Office Phone _____	Date of Last Exam _____
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		Yes	No			Yes	No	
1. Are you under medical treatment now?	<input type="checkbox"/>		<input type="checkbox"/>	7. Are you allergic or have a reaction to the following?				
2. Have you been hospitalized for any operation or illness within 5 years?	<input type="checkbox"/>		<input type="checkbox"/>	Local Anesthetics (Novocain)	<input type="checkbox"/>		<input type="checkbox"/>	
If yes, please explain _____				Penicillin or other Antibiotics	<input type="checkbox"/>		<input type="checkbox"/>	
3. Are you taking any medications?	<input type="checkbox"/>		<input type="checkbox"/>	Sulfa Drugs	<input type="checkbox"/>		<input type="checkbox"/>	
4. Do you use tobacco?	<input type="checkbox"/>		<input type="checkbox"/>	Barbiturates	<input type="checkbox"/>		<input type="checkbox"/>	
5. Do you use controlled substances?	<input type="checkbox"/>		<input type="checkbox"/>	Sedatives	<input type="checkbox"/>		<input type="checkbox"/>	
6. Women only:				Iodine	<input type="checkbox"/>		<input type="checkbox"/>	
Are you pregnant or think you may be?	<input type="checkbox"/>		<input type="checkbox"/>	Aspirin	<input type="checkbox"/>		<input type="checkbox"/>	
Are you nursing?	<input type="checkbox"/>		<input type="checkbox"/>	Any Metals (Nickel, Mercury)	<input type="checkbox"/>		<input type="checkbox"/>	
Are you taking oral contraceptives?	<input type="checkbox"/>		<input type="checkbox"/>	Latex Rubber	<input type="checkbox"/>		<input type="checkbox"/>	
8. Do you have or have you had any of the following?				Peanuts	<input type="checkbox"/>		<input type="checkbox"/>	
	Yes	No		Other (Please list) _____				
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Yes	No	Yes	No
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Aids or HIV Infection	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Stomach Troubles/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location _____	Date of Last Exam _____
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		Yes	No			Yes	No
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>		<input type="checkbox"/>	9. Do you have frequent headaches?		<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>		<input type="checkbox"/>	10. Do you bite your cheeks frequently?		<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet/sour liquids/foods?	<input type="checkbox"/>		<input type="checkbox"/>	11. Have you ever had any difficult extractions?		<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?	<input type="checkbox"/>		<input type="checkbox"/>	12. Have you ever had prolonged bleeding following extractions?		<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores/lumps in or near your mouth?	<input type="checkbox"/>		<input type="checkbox"/>	13. Have you ever had orthodontic treatment?		<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had any head, neck or jaw injuries?	<input type="checkbox"/>		<input type="checkbox"/>	14. Do you wear dentures or partials?		<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?				If yes, please explain _____			
Clicking	<input type="checkbox"/>		<input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>		<input type="checkbox"/>
Pain (joint, ear, side of face)?	<input type="checkbox"/>		<input type="checkbox"/>	16. Do you like your smile?	<input type="checkbox"/>		<input type="checkbox"/>
Difficulty in opening or closing?	<input type="checkbox"/>		<input type="checkbox"/>	17. Reason for visit _____			
Difficulty in chewing?	<input type="checkbox"/>		<input type="checkbox"/>				
8. Have you had problems with past dental treatment?	<input type="checkbox"/>		<input type="checkbox"/>				

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 payers and/or health practitioners. I authorize and request my insurance co. pay directly to the dentist 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 of my dependents.

X _____
Signature of patient (or parent of minor)