PATIENT INFORMATION

Date_____

Name_____ Soc. Sec. #_____ Driver's Lic. #_____
Last First Initial

Address_____ Home Phone (____)_____
City State Zip

Cell Phone (____) _____

e-Mail Address_____

Sex ☐ M ☐ F Birthdate_____ Age_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partner

Employer_____ Bus. Phone (____)_____
City State Zip

Spouse Name_____ Spouse's Soc. Sec. #_____

Spouse's Employer_____ Bus. Phone (____)_____
City State Zip

Who can we thank for referring you to us?_____

RESPONSIBLE PARTY/PRIMARY INSURANCE

Person Responsible for Account_____
Last Name First Name Initial

Relation to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other_____ Birthdate_____ Age_____

Soc. Sec. #_____ Driver's License #_____ State_____

Address (if different from patient's)_____ Home Phone (____)_____
City State Zip

Person Responsible Employed by_____ Bus. Phone (____)_____
City State Zip

Insurance Co._____ Group #_____

Names of other dependents covered under this plan_____

Credit Card No._____ Type_____ Expiration Date_____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_____ Relation to Patient_____ Birthdate_____

Address (if different from patient's)_____ Home Phone (____)_____
City State Zip

Subscriber Employer_____ Bus. Phone (____)_____

Insurance Co._____ Social Security No._____

Names of other dependents covered under this plan_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____
Name of Insurance Company(ies)

and assign directly to Family and Esthetic Dentistry of Hamden all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company(ies). I hereby authorize the doctor to release any and all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

Family and Esthetic Dentistry of Hamden Confidential Registration and Health History

DENTAL HISTORY

Reason for today's visit: ☐ Examination/X-rays ☐ Cleaning ☐ Cosmetic Consult ☐ Discomfort ☐ Other _____

If discomfort, where? _____ For how long? _____

How often do you visit the dentist? _____ Date of last visit _____ Date of last full set of x-rays _____

What did you have done? _____

How often do you: Brush? _____ Floss? _____ Any other cleaning aids? If so, what are they? _____

What are your long-term goals for your dental health and smile? _____

Would you like to change the appearance of your teeth? How? _____

What are your expectations of our office? _____

Please check if you have or have ever:

☐ Bad Breath	☐ Bleeding Gums	☐ Periodontal (Gum) Treatment	☐ Sensitive Teeth	☐ Sores/Growths/Swelling in your Mouth
☐ Worn Braces	☐ Bitten your fingernails	☐ Clench/Grind Your Teeth	___Cold ___Hot ___Sweets	☐ Clicking/Popping Jaw
☐ Extractions	☐ Root Canals	☐ Crowns/Bridges	☐ Worn a NightGuard	☐ Bleaching
☐ Food Collection between teeth		☐ Loose/Broken Fillings	☐ Dentures	

MEDICAL HISTORY

Physician's Name _____ Office Phone (_____) _____

Date of last visit _____ Reason for visit _____

Have you ever had any serious illnesses or operations? _____ If yes, please describe _____

(Women only) Are you pregnant? _____ Nursing? _____ Taking birth control pills? _____

Do you smoke? _____ How much? _____ How often _____ Do you drink excessive amounts of tea, coffee, or soda? _____

In case of emergency, please notify _____

Please check if you currently have or have ever had any of the following:

____ AIDS	____ Cold Sores (Herpes)	____ Hepatitis	____ Shortness of Breath
____ Anemia	____ Cough, Persistent	____ High Blood Pressure	____ Sinus Problems
____ Arthritis	____ Cough up blood	____ HIV Positive	____ Skin Rash
____ Artificial Heart Valves	____ Diabetes	____ Jaw Pain	____ Steroid Treatments
____ Artificial Joints	____ Eating Disorder	____ Kidney Disease	____ Stroke
____ Asthma	____ Epilepsy	____ Liver Disease	____ Swollen Feet/Ankles
____ Back Problems	____ Fainting	____ Mitral Valve Prolapse	____ Thyroid Problems
____ Bleeding/Clotting Problems	____ Glaucoma	____ Nervous Problems	____ Tobacco Habit
____ Blood Disease	____ Headaches	____ Pacemaker	____ Tonsillitis
____ Blood Transfusions	____ Head/Neck Injury	____ Psychiatric Care	____ Tuberculosis
____ Cancer	____ Heart Murmur	____ Radiation Treatment	____ Ulcer
____ Chemical Dependency	____ Heart Problems	____ Respiratory Problems	____ Venereal Disease(s)
____ Chemotherapy	Describe _____	____ Rheumatic Fever	____ Other
____ Circulatory Problems	____ Hemophilia	____ Scarlet Fever	Describe _____

MEDICATIONS

List all medications and dosages currently taking: _____

_____

_____

Pharmacy Name _____

Pharmacy Location _____

ALLERGIES

____Penicillin	____Sulfa
____Latex	____Codeine
____Local Anesthetic	____Aspirin

____Other medicines/drugs _____

_____

_____

I hereby attest that the above information I have provided is accurate and complete to the best of my knowledge. I understand that it is my responsibility to inform Family and Esthetic Dentistry of Hamden of any changes to any information provided on this form. I affirm that I will not hold Family and Esthetic Dentistry of Hamden or any of its staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____