WELCOME TO OUR OFFICE

Please take a moment to provide us with the requested information. This is necessary for us to better address your dental needs.

Name: _____ Address: _____

Today's Date: _____ Home phone: _____ City: _____ Zip:_____

Cell:_____Work phone:_____ Social Security #: _____

Date of birth: _____ Sex: M F Height: _____ Weight: _____

Place of work: _____ Occupation: _____

Marital status: _____ Name(s) of Spouse/Dependents: _____

_____ Email address:_____

Whom may we thank for referring you/how did you hear about our office? _____

Do you have dental insurance: Y N Company Name: _____

Who is responsible for any balance on this account? _____

What is the purpose of this visit? _____

• MEDICAL HISTORY •

Have you been hospitalized in the past two years? Y N If yes, what was the reason? _____

Have you been under the care of a physician in the past two years? Y N If yes, what is/was the reason? _____

_____

Are you currently taking any prescription drug(s)? Y N If yes, which one(s) (name & dosage) _____

_____

Are you allergic to PENICILLIN or ANY OTHER DRUG(S)? Y N If yes, which one(s)? _____

_____

Have you ever had any excessive bleeding requiring treatment? Y N

Please mark any of the following you are or have experienced:

☐ Heart disease	☐ Joint replacement*	☐ Asthma	☐ Herpes	☐ Hepatitis
☐ Artificial heart valve*	☐ Artificial implant*	☐ Diabetes	☐ Arthritis	☐ Jaundice
☐ Cardiac pacemaker	☐ Stroke	☐ Epilepsy	☐ Tuberculosis	☐ Sinus trouble
☐ High blood pressure	☐ Anemia	☐ Cancer treatment	☐ Persistent cough	☐ Food allergies
☐ Heart murmur	☐ Kidney treatment	☐ HIV/AIDS	☐ Psychiatric treatment	☐ Other allergies

Have you had any other serious illness, condition, or procedure not listed above? _____

*** For these conditions, do you take or have you been instructed to take premedication prior to dental treatment? Y N**

If yes, which medication(s) (name & dosage): _____

If female, are you pregnant? Y N Do you smoke? Y N Pack(s) per day _____ # years _____

Do you drink: tea coffee How many cup(s) per day? _____

• DENTAL HISTORY •

Do you brush daily? Y N Do you floss daily? Y N Do your gums bleed? Y N

Date of last dental treatment: _____ What was done? _____

Do you currently have any dental concerns? _____

I give Dr. J. DeFilippo, Dr. R. Rushin, or Dr. A DeFilippo permission to examine and treat me **Y N** or any dependent **Y N** according to their best judgement. I will cooperate fully in these matters. _____ *(initials)*

I understand that I am ultimately responsible for any fees for services rendered. Any balances past 90 days may be subject to an 18% annual interest charge and 15% collection fee. If outside agencies are necessary to help collect the balance, I am responsible for any costs incurred, including reasonable attorney's fees.

Patient Signature: _____

Reviewed by (office use only): _____ Date: _____

DENTAL ASSOCIATES OF WETHERSFIELD
FAMILY AND COSMETIC DENTISTRY