Health History Form

E-mail: X Today's Date:

American Dental Association
www.ada.org

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last, First, Middle) Home Phone: *Include area code* ( ) Business/Cell Phone: *Include area code* ( )

Address: (Mailing address) City: State: Zip:

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

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: ( ) Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

_____

_____

BACK --->

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications?_____			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink In a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease.	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: | Phone:

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: X | Date:

FOR COMPLETION BY DENTIST

Comments: _____

Financial Policy

STAMFORD DENTAL GROUP, LLC

47 Oak Street
2nd floor
Stamford, CT 06905

At Stamford Dental Group we know that providing complete comprehensive dental care includes discussing all treatment and financial information, before treatment is performed. Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care you need or desire.

Payment for services are due at the time services are rendered, unless prior arrangements have been made.

Payment options:

A. You can choose to pay by __cash, __check, or __credit card on the day that treatment is rendered.
B. On treatment involving laboratory fees (crowns, bridges, dentures, etc.) you have the option to pay 50% on the preparation date and the balance upon delivery of prosthesis. (Typically 3 weeks apart)
C. On extensive treatment, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution.
D. We offer special financing through Care Credit. (Upon credit approval) 0% interest for 12 months on purchases over $1,000+ longer term loans.
E. We also offer an in-office savings plan which is a low annual fee and gives you great discounts on services. (Please ask the front desk for additional information)

Payment options if you have insurance:

A. You can choose to pay your deductible of $_____ and any co-payments at the time services are rendered by __cash __check, or __credit card. (Metlife, Delta Dental, or Cigna patients only.)
B. You choose to pay all of your treatment by __cash, __ check, or __credit card. We will request your insurance carrier send their payment directly to you.
C. On treatment involving laboratory fees (crowns, bridges, dentures, etc.) you have the option to pay 50% on the preparation date and the balance upon delivery of prosthesis. (Typically 3 weeks apart)

Please understand that we will submit a claim to your insurance up to 2 times, as a courtesy to you. We will wait for a maximum of 45 days for payment for your insurance, after that you are responsible for the balance on the account. Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

Payments: If there are financial circumstances that prevent you from settling your account at the time of your visit we are more maybe able to work out a payment plan, **but you must communicate this with our patient accounts coordinator so arrangements can be made. Failure to do so in 60 days will result in collections action.**

Deposit Policy: Due to extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for appointments over 2 hours, we require a deposit of half of your treatment fee to make your reservation.

Initials_____

Charges to account: We shall have the right to cancel your future treatment if you have a 60 day outstanding balance. Future visits would then need to be paid in full at the time of service, regardless of balance, or insurance.

Past due accounts: If your account becomes 30-60 days past due, we will take necessary steps to collect this debt. We send out monthly statements and make several attempts to collect your balance. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. This may include court cost. If this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of a public record.

Returned checks: Checks that are returned to our office for insufficient funds are subject to a $35.00 returned check fee.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to sign a release form if you want to have copies of your records sent to another doctor or organization. It will take up to 24 hours for us to generate your records. You authorize us to include all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/ or workers compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment of your treatment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements need to be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Confidentiality: by signing this document you give us permission to share your info with other dentists, labs, etc.

By signing this form you give us permission to contact you via email, text.

Thank you for your consideration of this policy. We are glad that you have chosen our office as your oral healthcare provider.

Patient's name: _____

Responsible Party (if not the patient):_____

Signature: _____ Date: _____

Patient Registration Form

Stamford Dental Group, LLC, 47 Oak Street, 2nd Fl, Stamford, CT 06905

Name:_____

Home Address:_____Apt.#_____

City:_____State:_____Zip:_____

Home Phone:_____ Work:_____

Cell:_____Fax:_____

Social Security Number:_____ Date of Birth:_____

Single Married Divorced Widowed

E-Mail Address:_____

How were you referred to our office? _____

Can we contact you through the internet? ☐ Yes, you may. ☐ No, you may not.

Primary Dental Insurance

Name of Guarantor:_____

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Guarantor Name (If Different From Patient)_____

Social Security Number: _____

Date of Birth: _____

Please Note: As a courtesy, we will process your insurance claim(s). Please understand that we cannot process your insurance claim(s) until we have the proper insurance information. Please forward any questions and/or concerns directly to your insurance company. It is you, the patient, who has the relationship with your dental plan administrator and not our office. Notwithstanding insurance, the patient is responsible for payment at the time of service. For patients with insurance that we are in network with, we will accept partial insurance reimbursements(s) as payment. However, the patient remains responsible for any remaining balance not covered by their insurance company. I hereby authorize assignment of benefits to Stamford Dental Group, LLC.

Accepted Forms of Payment:
Cash, Check, Master Card, Visa, Discover Card, or Care Credit

_____ _____

Patient Signature/Parent if Minor Date