Dental Associates of Connecticut
Where our family cares for yours
SINCE 1971

ADULT HEALTH HISTORY

Please fill in your answers as thoroughly as possible. At Dental Associates of Connecticut, we are interested in developing a complete dental health program for you and your family. Be assured that all the information you give us is kept in strict confidence and in accordance with US government privacy regulations. Thank you.

Date: _____

Patient Name: _____ ❒ M ❒ F
Last Name First Name Middle Initial

Street Address: _____

Mailing Address: _____
(if different from Street Address)

City: _____ State: _____ Zip Code: _____

Date of Birth: _____/_____/_____ Social Security #: _____–_____–_____ Marital Status: _____
MM/DD/YYYY M/S/D/W

Home Phone: _____ Cell Phone: _____Work Phone: _____

How would you prefer we confirm your appointments? ❒Home ❒Cell ❒Work ❒Text ❒Email

For email reminder, please provide your email address: _____

Employer: _____Position: _____

Employer Address: _____

Phone Number: _____ Ext: _____How Long? _____

Spouse's Name: _____ Social Security #: _____–_____–_____ Date of Birth: _____

Employer: _____Position: _____

Employer Address: _____

Phone Number: _____ Ext: _____How Long? _____

Name(s) & age(s) of children living at home: _____

Nearest Relative/Friend: _____ Phone: _____
(in case of emergency)

Dental Insurance Company Name(s): Policy Holder Group Policy

_____

_____

How did you hear about us?

❒ A family member or friend is a patient here. Who may we thank for this referral? _____

❒ Newspaper/Magazine ❒ Television ❒ Radio ❒ Sign on Building ❒ Direct Mail

❒ Community Event _____
(please specify)

❒ Internet Search _____ ❒ Other _____
(please specify – i.e. Google search, Bing, Yahoo!, Invisalign website, insurance website, etc) (please specify)

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MEDICAL HISTORY

My last physical exam was on (date): _____/_____/_____ Physician: _____

Address of Physician: _____ Phone: _____

Have you been hospitalized within the past 3 years? ❒ No ❒ Yes If yes, date(s) & why? _____

Have you had any serious illness or operation? ❒ No ❒ Yes If yes, date(s) & why? _____

Do you need to pre-medicate before dental treatment? ❒ No ❒ Yes ❒ Not sure

If yes, please state duration of premedication & prescribing doctor: _____

Do you have, or have you had, any of the following? *Please circle your answers*

Arthritis or other joint problems	Yes	No	Heart murmur, mitral valve prolapse	Yes	No
Asthma, breathing problems	Yes	No	Hepatitis, jaundice, or liver problems	Yes	No
Blood transfusions	Yes	No	HIV/AIDS	Yes	No
Blood Pressure Issues (High or Low)	Yes	No	Kidney problems	Yes	No
If Yes, please specify which: _____			Osteoporosis / bone density issues	Yes	No
Cancer/chemotherapy/radiation	Yes	No	Pregnant or Nursing	Yes	No
Congenital heart defects	Yes	No	*If Yes, When are you due?* _____		
Diabetes (high or low blood sugar)	Yes	No	Previous infective endocarditis	Yes	No
Do you smoke?	Yes	No	Prosthetic heart valves	Yes	No
If yes, how much? _____ *pack(s) Day/ Week*			Prosthetic joint replacement	Yes	No
Drug/Alcohol addiction (past or present)	Yes	No	Psychiatric problems	Yes	No
Fainting spells, seizures, epilepsy	Yes	No	Seasonal Allergies	Yes	No
G.E.R.D/Acid reflux disease	Yes	No	Thyroid (hyper/hypo)	Yes	No
Growths or tumors	Yes	No	Tuberculosis	Yes	No
Heart attack, angina, or stroke	Yes	No	Ulcer or stomach problems	Yes	No
If Yes, please specify which: _____					

If you circled YES for any of the above, or if you have any disease, condition, problem or concern not listed, please explain: _____
_____

Medications – *Please specify the drug name, dosage and reason for use. Please include over the counter medications.*

Name of Drug Dosage Condition

_____
_____

Allergies – *Are you allergic, or have had an adverse reaction, to:*

❒Novocain/local anesthetics ❒Codeine/other narcotics ❒Jewelry or metals ❒Latex ❒Epinephrine (EPI)
❒Barbiturates/sedatives ❒Sulfa drugs ❒Aspirin ❒Penicillin
❒Other antibiotics: _____ (please specify) ❒Food allergies: _____ (please specify) ❒Other: _____ (please specify)

Do you carry an EPI Pen? **YES/NO** (please circle)

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DENTAL HEALTH

Previous/current dentist: _____ Phone: _____
Address: _____
What has prompted you to seek dental care at this time? _____
How long has it been since your last thorough dental exam? _____
When did you last have x-rays taken of all of your teeth? _____
Have you had any serious trouble associated with any previous dental treatment? _____ Yes _____No
If yes, please explain: _____
_____

Do you currently have, or have had, any of the following? *Please circle any that apply.*

Broken fillings	Past	Present	Clenching or grinding of teeth	Past	Present
Cavities	Past	Present	Pain in the ear region	Past	Present
Endodontic treatment (root canal)	Past	Present	Headaches/Neck aches	Past	Present
Orthodontics (braces of any kind)	Past	Present	Clicking in the ear while eating	Past	Present
Bleeding gums	Past	Present	Herpes/frequent blisters (cold sores)	Past	Present
Sensitive teeth	Past	Present	Swellings or lumps in the mouth	Past	Present
Periodontal (gum) treatment	Past	Present	Sinus problems	Past	Present
Snoring/sleep apnea	Past	Present	Halitosis (bad breath)	Past	Present

If yes, do you use a CPAP machine or other sleep apnea appliance? **YES/NO** (please circle)

How would you rate your current dental condition? ❒ Excellent ❒ Good ❒ Fair ❒ Poor ❒ Not Sure

When you have your dentistry performed, do you prefer:

Xylocaine (Novocain)	❒ Sometimes	❒ Always	❒ Never
Nitrous Oxide (laughing gas, sweet air)	❒ Sometimes	❒ Always	❒ Never
Sleep Dentistry/IV Sedation	❒ Sometimes	❒ Always	❒ Never

Are you nervous or frightened during dental visits? ❒ Sometimes ❒ Always ❒ Never
If so, please rate your anxiety level *(circle one)* ***Not Nervous*** 0 1 2 3 4 5 6 7 8 9 10 ***Extremely Nervous***

AESTHETICS

Do you smile with confidence?	❒ Yes	❒ No
Do you love the appearance of your teeth?	❒ Yes	❒ No
Are you happy with the whiteness of your teeth?	❒ Yes	❒ No
Do your restorations (crowns, fillings, etc) look natural?	❒ Yes	❒ No
Do you like the way your teeth are shaped?	❒ Yes	❒ No

When you look at your smile in the mirror, do your teeth and gums appear healthy? ❒ Yes ❒ No

Have you ever used a tooth whitening regimen? If so, what type? _____

If you could alter your smile, what would you most like to change? _____

Please let us know what you look for most when choosing a dentist. _____

To the best of my knowledge, the above information is complete and accurate. I understand that even though I may have some type of insurance coverage, I am responsible for payment for services rendered. If deemed necessary by Dental Associates, my credit may be checked. I authorize release of any information to my insurance company relating to my dental claims.

PATIENT'S SIGNATURE _____ *DATE* _____

DOCTOR'S SIGNATURE _____ *DATE* _____

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Notice of Privacy Practices Acknowledgement and Consent

By signing below, I acknowledge that I have been provided a copy of the Dental Associates of Connecticut, PC Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this Notice, and how I may obtain access to and control this information.

By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff and its business associates.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

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