SOUTHERN CONNECTICUT DENTAL GROUP
General, Pediatric & Cosmetic Dentistry

Ansonia Office
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Ansonia, CT 06401
203.735.4701

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30 Quaker Farms Road
Southbury, CT 06488
203.264.4351

www.southernCTdental.com

PATIENT REGISTRATION AND HEALTH HISTORY

Date _____ M ☐ F ☐ Birth Date _____

Patient's Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

PLEASE CHECK WHICH NUMBER IS BEST TO REACH YOU:

☐ Home Phone _____ ☐ Cell Phone _____

Email _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status _____

Residence _____ How Long? _____

Mailing Address _____ Home Phone _____

Social Security # _____ Birth date _____ Relationship to Patient _____

Employer _____ Occupation _____ # years employed _____

Work Phone _____ Cell Phone _____ Email _____

Spouse's Name _____ Relationship to Patient _____

Employer Occupation _____ # years employed _____

Social Security # _____ Birth date _____ Work Phone _____

INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group # _____ Local # _____

Insurance Company Address _____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group# _____ Local # _____

Insurance Company Address _____

Insured's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Cell Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

HEALTH HISTORY

1. When was your last dental visit? _____
2. Are you having pain or discomfort at this time? ..... Yes No
3. Do you feel very nervous about having dental treatment? ..... Yes No
4. Have you ever had a bad experience in the dental office? ..... Yes No
5. How would your smile rate on a scale of 1-10? _____
6. Do you clench or grind your jaw while sleeping or during the day? ..... Yes No
7. Have you been a patient in the hospital during the past two years? ..... Yes No
8. Have you been under the care of a medical doctor during the past two years? ..... Yes No

   Physician's Name _____

   Address _____ Phone _____

9. Have you taken any medicine or drugs during the past two years? ..... Yes No
10. Are you currently taking any medicine, drugs, or pills? ..... Yes No
11. Please list medications _____
12. Are you aware of being allergic to, or have you ever reacted adversely to any medication or substance? ..... Yes No

    ☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Other

    If yes, please list: _____

13. Indicate which of the following you have had or have currently.

Heart Disease or Attack.....	Yes No	Emphysema	Yes No	Liver Disease	Yes No
Angina	Yes No	Tuberculosis (TB).....	Yes No	Yellow Jaundice	Yes No
High Blood Pressure	Yes No	Asthma.....	Yes No	Blood Transfusion	Yes No
Heart Murmur	Yes No	Sinus Trouble	Yes No	Drug Addiction	Yes No
Rheumatic Fever	Yes No	Allergies or Hives	Yes No	Hemophilia	Yes No
Congenital Heart Lesions	Yes No	Diabetes	Yes No	Venereal Disease	
Artificial Heart Valve	Yes No	Thyroid Disease	Yes No	(Syphilis, Gonorrhea)	Yes No
Pacemaker	Yes No	X-ray or Cobalt Treatment.....	Yes No	Cold Sores	Yes No
Heart Surgery	Yes No	Chemotherapy (Cancer, Leukemia)	Yes No	Fever Blisters	Yes No
Artificial Joints (Hip, Knee) .	Yes No	Arthritis.....	Yes No	Epilepsy or Seizures	Yes No
Anemia	Yes No	Cortisone Medicine.....	Yes No	Fainting or Dizzy Spells	Yes No
Stroke.....	Yes No	Glaucoma.....	Yes No	Nervousness	Yes No
Kidney Trouble	Yes No	Pain in Jaw Joints	Yes No	Psychiatric Treatment	Yes No
Ulcers	Yes No	A.I.D.S.	Yes No	Sickle Cell Disease	Yes No
Cosmetic Surgery	Yes No	Hepatitis.....	Yes No	Bruise Easily	Yes No

14. When you walk stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired ..... Yes No
15. Has your medical doctor ever said you have a cancer or tumor? ..... Yes No
16. Do you have any disease, condition, or problem not listed? ..... Yes No
17. Are you aware of any swelling or lump in your mouth? ..... Yes No
18. Are you subject to prolonged bleeding? ..... Yes No

FOR FEMALE PATIENTS ONLY:

Are you pregnant? ☐ Yes ☐ No If yes, what month? _____ Are you taking birth control pills? ☐ Yes ☐ No

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I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

CONSENT:

The undersigned hereby authorizes Southern Connecticut Dental Group to take x-rays, study models, photographs, or any diagnostic aids appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Southern Connecticut Dental Group to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Southern Connecticut Dental Group choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. Balances not paid within 60 days will incur 1 $^{1}/_{2}$% per month (18% annual) interest charge. I further understand that in the event of default (I) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to affect collection of this note.

Signature _____ Date _____