Middlebury Dental Group
415 Middlebury Road
Middlebury, CT 06762, (203) 758-2116
www.middleburydentalgroup.com

PATIENT INFORMATION

Date _____ Title: Mr./Mrs./Ms/Other _____

Patient Name _____ Nickname _____ Birthdate _____

Sex: M _____ F _____

Address _____

City _____ State _____ ZIP _____

Home Phone _____

Cell Phone _____ Would you prefer to be contacted by home or cell? _____

Business Phone (provide only if you can receive calls at this number) _____

E-mail _____

Patient Employed By _____ Occupation _____

Business Address _____

_____

For Students – School Attending _____ FT / PT (circle one)

If under age 18, Parent or Guardian's Name _____

In case of emergency contact _____ Relation _____

Address _____

City _____ State _____ ZIP _____

Home Phone _____

Cell Phone _____

Who may we thank for referring you? _____

DENTAL INSURANCE INFORMATION

Please provide us with your insurance cards

Dental Insurance Company Name _____

Cardholder (Employee / Subscriber) Name _____ DOB _____

Subscriber ID # _____

Employer Name _____

Is patient covered by additional dental insurance? Yes _____ No _____

Dental Insurance Company Name _____

Cardholder (Employee / Subscriber) Name _____ DOB _____

Subscriber ID # _____

Employer Name _____

INSURANCE ASSIGNMENT AND RELEASE

Please read and sign below if you wish the insurance benefit to be paid directly to (Middlebury Dental Group, Dr.'s Smith and Mandava.)

I, the undersigned, certify that I have insurance coverage with (name of insurance company) _____ and assign directly to Middlebury Dental Group, 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 insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____ **Date** _____

MEDICAL HISTORY

Physician Name _____ Phone _____

Pharmacy Name _____ Phone _____

Are you under the care of a physician now? Yes ___ No ___ If yes, what are you being treated for? _____

Ever been hospitalized or had a serious illness within the last 5 years? Yes ____ No ____ If yes, please explain below:

_____

Do you have to be premedicated before a dental procedure (joint replacement, heart valve)?
Yes ____ **No**____ If yes, please list medication(s) below:

_____

List any medications you are presently taking (please include strengths)

_____

_____

_____

_____

Are you presently taking bisphosphonates, i.e. Fosamax, Actonel, Boniva, etc.? Yes ___ No ___
Are you allergic to any medications or anethetics? Yes ___ No ___ If yes, please list below:

_____

Are you allergic to Latex? Yes ___ No ___

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING (CHECK YES OR NO)

	YES	NO		YES	NO
Heart Trouble / Murmur / Stroke (circle one).....	☐	☐	Jaundice.....	☐	☐
Heart Valve Prolapse / Defect / Replacement.....	☐	☐	Joint Replacement - If yes, when?_____	☐	☐
Heart Pacemaker.....	☐	☐	Anemia / Blood Transfusion.....	☐	☐
Hepatitis A ____B____C____When?_____	☐	☐	High / Low Blood Pressure (circle one).....	☐	☐
AIDS or ARC.....	☐	☐	Tuberculosis -If yes, when? _____	☐	☐
Hemophelia / Abnormal Bleeding.....	☐	☐	Sleep Sitting Up.....	☐	☐
Diabetes.....	☐	☐	Venereal Disease.....	☐	☐
Asthma.....	☐	☐	Tumor / Cancer - Benign / Malignant (circle one)	☐	☐
Breathing Difficulty.....	☐	☐	Epilepsy.....	☐	☐
Breathe Through Your Mouth.....	☐	☐	Frequent or Severe Headaches.....	☐	☐
Thyroid Disorder.....	☐	☐	Mental/Behavioral Condition.....	☐	☐
Radiation / Chemotherapy.....	☐	☐	Gastrointestinal Disorders.....	☐	☐
Seizure Disorder.....	☐	☐	Alcohol Dependency.....	☐	☐
Extremely Nervous (in general).....	☐	☐	Muscular Disorder.....	☐	☐
Stomach Ulcers.....	☐	☐			
Special Diet.....	☐	☐	Are You Pregnant.....	☐	☐
Drug Dependency.....	☐	☐	Are You Nursing.....	☐	☐

IN YOUR WORDS – WHAT BRINGS YOU TO OUR OFFICE?

	YES	NO		YES	NO
Are you in pain.....	☐	☐	Experiencing bad taste or mouth odor.....	☐	☐
Bleeding gums.....	☐	☐	Previous gum treatments.....	☐	☐
Jaw clicking or popping.....	☐	☐	If yes, when? _____		
TMJ disorder.....	☐	☐	Do you clench or grind your teeth.....	☐	☐
Worn braces.....	☐	☐	Teeth sensitive to hot or cold	☐	☐
			Do you have dental implants.....	☐	☐

Do you object to wearing dentures? _____
If you currently have dentures or partial dentures, how old are they? _____
Fever blisters / Mouth Sores? _____
What type of toothbrush do you use? Soft____ Medium____ Hard____
How often do you brush?_____ How often do you floss?_____
When was your last cleaning? _____ Last Full Mouth X-Rays? _____
Have you ever had a traumatic dental experience? _____
Are you dissatisfied with the appearance of your teeth? _____
Do you wish your teeth were whiter? _____
Do you snore? _____Have you ever had a sleep study? _____

I hereby state that the answers to the questions above are correct to the best of my ability. I furthermore promise to take it upon myself to inform this office of any changes in my medical history prior to subsequent dental treatments. I understand that I am financially responsible for all charges, regardless of any insurance involvement. In the event that payment for dental services is not made within sixty (60) days from treatment date, then interest will be charged at the rate of 1.8% monthly (21.6% annually) to the past due balance. I further agree to pay all collection or legal fees, including interest charges, associated with obtaining payment for the outstanding balance.

We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice.

Signature_____ **Date**_____