546 South Broad Street
Meriden, CT 06450 Dental Implants & Periodontics of Connecticut, LLC 203-630-1312

First Name__________________ Last Name_____________________ Preferred Name ____________________

How would you like to be contacted? □ **Email** □ **Text** □ **Phone**

Address____

City____ State ___________________ Zip Code________________________

Home (_____)___________________Work (_____)________________________ Cell (____) ______________________

E-Mail Address____

Social Security Number______-__________-_______ Birthdate____/_____/_____ Marital Status__________________

What pharmacy do you use? ______________________________Town:____

Occupation_______________________________ Name of Employer ____

Emergency Contact Name ____

Telephone Number (___) __________________________Relationship__________________________

Name of General Dentist____

How long have you been with your general dentist __________________________Telephone # (___)_______________________

Who were you referred by?____

Part II Employer/Insurance Information

Name of **Primary Dental Plan**____

Name of the Policy Holder_______________________________ Date of birth____/____/_____ Relationship_____________

Subscriber Identification Number_______________________________________ Group Number______________________

Employer Name____ Employer telephone Number (____)________________

Name of **Secondary Dental Plan**____

Name of the Policy Holder_______________________________ Date of birth____/____/_____ Relationship_____________

Subscriber Identification Number_______________________________________ Group Number______________________

Employer Name____ Employer telephone Number (____)________________

□ **I do not have dental insurance**

Part III Assignment of Benefits

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above noted dental entity.

____ Date ___________________________________

Signature of the insured

I authorize the Office of Dental Implants and Periodontics of Ct. to submit insurance claims electronically or via paper claim

____Date___________________________________

Signature of the insured

All patients must sign below that they understand our financial policy.

I agree to pay for services in full. I understand that the office will assist me in submitting any insurance claims, any remaining balance after insurance has paid will be my responsibility. If I do not have insurance I understand that I am financially responsible for any and all services rendered to me.

____ Date____

Signature of patient or guardian of patient

I agree to pay a finance charge of 1.5 % a month or 18% annually on any unpaid balance. I also agree to pay collection cost and reasonable attorney fees for any delinquent balance placed with a collection agency or attorney for collection.

____ Date____

Signature of patient or guardian of patient

Appointment Cancellation Policy

Thank you for choosing Dental Implants and Periodontics of CT!

We value your time and as such, have set aside time in your, and our, schedule to address your dental health needs and concerns. Therefore, we have an **Appointment Cancellation Policy** in place to ensure our commitment to providing all patients with exceptional care. When a scheduled appointment is cancelled without notice, it takes away the opportunity for another patient to be seen.

While we do understand emergencies may arise, we require a **48 hours notice** when you need to reschedule your appointment. To cancel a Monday appointment, please call our office by 1:00 p.m. on Friday. Failure to notify us results in a missed appointment fee as follows:

Routine hygiene visit missed appointment fee: $100.00
Surgery missed appointment fee: $250.00
New Patient appointment fee:

This fee cannot be billed to insurance and is your direct responsibility. Additionally, no future appointments can be schedule without payment of this fee.

I have read and understand the Appointment Cancellation Policy of your practice and agree to the terms. I also understand such terms may be amended by the practice.

____ __________________

Patient Signature (Parent/Guardian if under 18) **Date**

Part IV Medical Information

Patient Name:___________________________________

1. Name of your Physician____
   Address of your Physician____
   Telephone Number (________)______________________________

2. **List ALL prescription and non-prescription medications you're currently taking (We can photocopy a list):**
   ____
   ____

3. Do you take Aspirin? Yes No How many mg? _________

4. Do you have or have had any of the following conditions?

Alcohol Abuse	□Yes	□No	High Blood Pressure	□Yes	□No
Angina Pectoris	□Yes	□No	HIV/Aids	□Yes	□No
Arthritis	□Yes	□No	Kidney Problems	□Yes	□No
Artificial Heart Valve	□Yes	□No	Liver Disease	□Yes	□No
Artificial Joint	□Yes	□No	Mitral Valve Prolapse	□Yes	□No
Asthma	□Yes	□No	Osteoporosis	□Yes	□No
Blood Transfusion	□Yes	□No	Pace Maker	□Yes	□No
Cancer – Chemotherapy	□Yes	□No	Pain in Jaw Joints	□Yes	□No
Congenital Heart Defect	□Yes	□No	Psychiatric Problems	□Yes	□No
Coumadin	□Yes	□No	Radiation Therapy	□Yes	□No
Diabetes	□Yes	□No	Sinusitis	□Yes	□No
Drug Abuse	□Yes	□No	Respiratory Problems	□Yes	□No
Emphysema	□Yes	□No	Seasonal Allergies	□Yes	□No
Epilepsy	□Yes	□No	Stroke	□Yes	□No
Fainting Spells	□Yes	□No	Thyroid Disease	□Yes	□No
Hepatitis	□Yes	□No	Tumor or Growth	□Yes	□No
Heart Murmur	□Yes	□No	Tuberculosis	□Yes	□No
Heart Surgery/Attack	□Yes	□No	Ulcers	□Yes	□No
Other: __________________			Yellow Jaundice	□Yes	□No

If Diabetic what is your **A1C** level and when was it last tested ________________________________

5. Do you pre-medicate prior to dental appointments? □Yes □No
If yes, indicate the name of the medication_____________________________dosage ____________________________

6. Have you ever had a serious illness or major operation? □Yes □No
If yes, please explain____

7. Have you had abnormal bleeding associated with previous tooth extraction, surgery or trauma? □Yes □No
If yes, please explain____

8. Are you allergic or have had an adverse reaction to any of the following:

Aspirin	□Yes	□No	Codeine	□Yes	□No
Dental Anesthetics (novacaine, lidocaine, etc.)	□Yes	□No	Erythromycin	□Yes	□No
Jewelry	□Yes	□No	Latex	□Yes	□No
Penicillin	□Yes	□No	Tetracycline	□Yes	□No

Other____

10. Do you smoke? □Yes □No If yes, how much and for how long have you been smoking ?
____

11. Have you ever had a problem with substance or alcohol abuse? □Yes □No
If yes, please explain____

For Women Only

1. Are you currently taking any oral contraceptives? □Yes □No
2. Are you pregnant? □Yes □No

Part V Dental History

1. What brings you to our office? ____

2. Are you currently experiencing any dental pain? ____

3. When was your last dental cleaning? ____

4. How frequently do you have your teeth professionally cleaned? ______________________________

5. How frequently do you floss your teeth? ____

6. Do you use an electric toothbrush? □Yes □No If yes, what kind? ______________________

7. Do you wear removable dentures? □Yes □No If yes, how old are they? ___________________

8. Do you grind your teeth? □Yes □No If so, when? ______________________________

9. Do you wear a night guard? □Yes □No

10. Are you aware of:

Painful Gums	□Yes	□No	Shifting or loose teeth	□Yes	□No
Bad Breath	□Yes	□No	Receding Gums	□Yes	□No
Sensitive Teeth	□Yes	□No	Gagging	□Yes	□No

11. Have you ever been told that you have "trench mouth" or periodontal disease (pyorrhea)? Yes No

12. Please describe any previous periodontal treatment that you may have had: ______________________
____

13. Have you ever had any complications associated with previous dental treatment? If so please explain,
____

14. Has anyone in your family been diagnosed with periodontal disease? Yes No If yes, indicate whom____

Please indicate if there is any person or entity that you would not give permission to disclose your Protected Health Information to: ***____***

Patient Signature ____ Date ____________________