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?_____

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**

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.

We require **48 business hours of notice** when you need to reschedule your appointment. To cancel a Monday appointment, please call our office by 1:00 p.m. on Thursday. 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: You will be charged the consult fee and may not be rescheduled.

This fee cannot be billed to insurance and is your direct responsibility. Additionally, no future appointments can be schedule without payment of this fee. We understand that emergencies and illness can unexpectedly arise, and will not charge for such instances reported within the 48 hour time frame.

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**

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 (You can email/we can photocopy a list):**
   _____
   _____

3A. Do you take Aspirin? Yes No How many mg? _____
3B. I CANNOT take any of the following: □ ibuprofen □ Tylenol

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

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 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_____

The sharing of your personal information with any entity other than the dentist by whom you have been referred can only be done with a Release of Records form signed by you. In the event of an emergency, we must share your information with local authorities if requested.

Patient Signature _____ Date _____