141 Captain Thomas Boulevard
West Haven, CT 06516
Tel: (203)932-3675 – Fax: (203)934-9701

PATIENT INFORMATION

PERSONAL

☐Mr. ☐Ms. ☐Rev. ☐Mrs. ☐Miss ☐Dr.	Full Legal Name: Last First Middle	
☐Female ☐ Male	Date of Birth (Month/Day/Year):	Preferred Name:
Mailing Address:		
City:	State:	Zip Code:	Email:
Home Phone Number ( ) -	Work Phone Number ( ) -	Cell Phone Number ( ) -
Best Number For Contact: ☐Home ☐Work ☐Cell		
Names of Parents or Legal Guardians if Patient is a Minor		

EMERGENCY CONTACT

Emergency Contact: Last First Middle		
Relationship	Home Phone Number ( ) -	Other Phone Number ( ) -

EMPLOYER AND INSURANCE INFORMATION

Employer Name:	Address:	Phone Number:
Insurance Company Name		
Policy Holder: Date of Birth:	Subscriber #	Group #

☐Same as Patient RESPONSIBLE PARTY INFORMATION

Full Legal Name: Last First Middle			Relationship to Patient	
Mailing Address	City	State	Zip Code	Date of Birth
Home Phone Number ( ) -		Other Phone Number ( ) -		

REFERRAL INFORMATION

How did you hear about our office?
☐Family/Friend _____ ☐Referring Doctor _____
☐Insurance Company ☐Internet

I hereby certify that the above information is true and correct. I understand it is my responsibility to notify the office of any changes.

Signature: _____ Date: _____

West Shore FAMILY DENTAL

Today's Date: _____

Name: _____

Adult Dental History

What is the reason for your dental visit today?	Date of your last dental x-rays?
Date of your last dental visit?	What was done at that visit?

Previous dentist's name: _____ Address: _____

City/State: _____ Phone Number: _____

Dental Information: Please mark your response to the following questions. If you are not sure or don't know the answer to the question, please mark Don't Know (DK)

Do your gums bleed when you brush or floss? Yes No DK Are your teeth sensitive to cold, hot, sweets or pressure? Yes No DK Does food or floss catch between your teeth? Yes No DK Is your mouth dry? Yes No DK Have you had any periodontal (gum) treatments? Yes No DK Have you had problems with previous dental treatment? Yes No DK Is your home water supply fluoridated? Yes No DK Do you drink bottled or filtered water? Yes No DK If yes, how often? Daily Weekly Occasionally Do you have earaches or neck pain? Yes No DK	Do you have clicking, popping or jaw discomfort? Yes No DK Do you grind or clench your teeth? Yes No DK Do you wear a night guard? Yes No DK Do you have sores or ulcers in your mouth? Yes No DK Did you have orthodontic treatment? Yes No DK Do you wear dentures or partials? Yes No DK Do you participate in active recreational sports? Yes No DK Have you had a serious injury to your head or mouth? Yes No Are your currently experiencing discomfort? Yes No If yes, please explain: _____

How often do you brush your teeth? _____ Manual Brush Electric Brush

Do you use fluoride toothpaste? Yes No Don't Know

How often do you floss your teeth? _____

Do you use a fluoride or anti-cavity rinse? Yes No Don't Know

If yes, what brand? _____

Have you ever been diagnosed with sleep apnea or other sleep disorder? Yes No Don't Know

SMILE SATISFACTION

Do you like to smile and show your teeth?	Yes	No
Are you happy with the way your teeth look?	Yes	No
Are your teeth as white as you would like them to be?	Yes	No
Are your teeth as straight as you would like them to be?	Yes	No
Are you self-conscious of your denture or partial when you are eating out with friends?	Yes	No
Are you missing teeth?	Yes	No
If yes, are you interested in replacing teeth?	Yes	No
Can you easily eat all the foods you want to enjoy?	Yes	No
Are your gums tender?	Yes	No
Are you concerned about bad breath?	Yes	No
Are you anxious or fearful about dental treatment?	Yes	No
Are you interested in changing your smile through cosmetic dentistry?	Yes	No

Today's Date: _____

Name: _____

Adult Medical History

Medical Information

Are you now under the care of a physician?	**Yes No**	Have you had a serious illness, operation or been hospitalized in the last five years?	**Yes No**
Physician's Name/ Phone Number (include area code)		If yes, what was the illness, problem or operation?	
Physician's Address/City/State			
Describe your health (Circle One): **Very Poor Poor Good Very Good Excellent**			
Has your general health changed within the last year?	**Yes No**	Are you taking or have you recently taken any prescription over the counter medication(s)? If yes, please list all with dosage, including vitamins, natural or herbal preparations and/or diet supplements: _____ _____ _____ _____	**Yes No**
If yes, please describe this change:			
Date of last physical exam:			

Do you have or have you had any of the following conditions? (Please (x) all that apply)

Conditions Requiring Antibiotic Prophylaxis
- Artificial Joint/Joint Replacement
- Organ Transplant
- Artificial (Prosthetic) Heart Valve
- Previous infective endocarditis
- Damaged valves
- Congenital Heart Disease

Cardiovascular Diseases
- High Blood Pressure
- Hardening of arteries
- Angina
- Congestive Heart Failure (CHF)
- Heart Attack
- Heart Bypass/Stent Surgery
- Pacemaker
- Valvular Prolapse
- Swollen ankles
- Lower leg cramps

Blood or Lymphatic Diseases
- Anemia
- Sickle Cell Disease/Trait
- Bleeding Disorder
- HIV/AIDS
- Leukemia/Lymphoma
- Take blood thinners
- Chronic fatigue
- Easy or frequent bruising
- Frequent colds or infections
- Swollen lymph nodes

Respiratory Diseases
- Tuberculosis
- Asthma
- Bronchitis, COPD, Emphysema
- Sleep apnea
- Persistent cough
- Coughing up blood
- Shortness of breath
- Wheezing
- Other lung condition

Liver or Gastrointestinal Diseases
- Hepatitis
- Liver cirrhosis
- Jaundice
- Gall bladder stones/disease
- GERD/Reflux/Ulcers/Heartburn
- Constipation/Diarrhea
- Blood in stool/Dark Stools
- Frequent vomiting

Neurological or Mental Disorders
- Stroke/TIA/Mini stroke
- Epilepsy/Seizures
- Dementia/Alzheimer's
- Generalized Anxiety
- Depression
- Treatment of emotional condition
- Numbness in extremities
- Any other nerve condition
- Any other disorder (i.e. Schizophrenia)

Endocrine Diseases
- Diabetes
- Thyroid Disorder
- Other endocrine disease

Miscellaneous Diseases
- Arthritis
- Kidney disease
- Organ transplant
- Cancer
- Radiation
- Chemotherapy
- Sexually Transmitted Disease (STD)
- Skin condition
- Night sweats
- Fever
- Unexpected weight loss/gain

HEENT Conditions
- Hear ringing or other noises
- Ear pain, discharge
- Dizziness
- Vision changes
- Blurred vision, double vision
- Glaucoma
- Runny nose/Nose bleeds
- Difficulty swallowing
- Headaches/Migraines
- Numbness/Tingling of Face

Any other condition not mentioned?

West Shore FAMILY DENTAL

Today's Date: _____

Name: _____

Adult Medical History Continued

Do you wear contact lenses?	**Yes No**	Do you use controlled substances? (Drugs) If yes, please describe use: _____	**Yes No**
Joint Replacement: Have you had an orthopedic total joint replacement? If yes, what joint? Date: _____	**Yes No**	Do you have a history of tobacco use? If yes, what form? _____ Amount per day: _____ Duration of use (years):_____	**Yes No**
Are you taking or scheduled to begin taking Fosamax/Aledronate or Actonel/Risedronate) for osteoporosis or Paget's disease?	**Yes No**	Do you have a history of alcoholic beverage consumption? If yes, please indicate amount per day and duration of habit: _____	**Yes No**
Were you treated or are you currently scheduled to begin treatment with the intravenous bisphosphonates for: pain, skeleton complication from Paget's disease, multiple myeloma or metastatic cancer? Date Treatment Began:_____ Date Treatment Ended:_____	**Yes No**	WOMEN ONLY. Are you: Taking contraceptives? What type: _____ Pregnant? Number of weeks:_____ Taking hormonal replacement? Nursing?	 **Yes No** **Yes No** **Yes No** **Yes No**

If you are not sure or don't know the answer to the question, please mark "DK".

Allergies	**Yes**	**No**	**DK**	**Allergies**	**Yes**	**No**	**DK**
Local Anesthesia				Latex (Rubber)			
Aspirin				Iodine			
Penicillin or other antibiotic				Hay Fever/Seasonal			
Barbiturates or Sedatives				Animals			
Sulfa Drugs				Food			
Codeine or other narcotics				Other			
Metals							

Please describe your reaction for any of the above allergies:

Do you have any disease, condition or problem not listed above that you think we should know about?
Please explain: _____

Preferred Pharmacy: _____

City: _____ **State:** _____ **Phone Number:**_____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that West Shore Family Dental will rely on this information for treating me. I will inform the office if there are any changes in my health and/or medications.

Signature of Patient/Legal Guardian: _____ Date:_____

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PERMISSION TO SHARE INFORMATION

Patient Name: _____ Date of Birth:_____

One of our goals is to protect your right to privacy; therefore, unless we have your permission, information will not be given to anyone regarding your oral health care and/or finances.

May we call you at work? ☐ Yes ☐ No

May we call you at home? ☐ Yes ☐ No
If no to both questions above, do you have an alternative Number (i.e. cell phone)? _____

May we leave messages, including appointment information, on your answering machine or voicemail? ☐ Yes ☐ No

May we speak with your spouse, significant other or family member regarding your personal health information and/or any financial arrangements? ☐ Yes ☐ No
If yes, what is your relationship and the name of this person?
_____

Is there another person we may release your personal health information to? We will only provide information to those listed below. ☐ Yes ☐ No

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

May we send you a fax? ☐ Yes Fax#:_____ ☐ No

May we send you an email? ☐ Yes Email Address: _____ ☐ No

Patient/Guarantor Signature: _____ Date:_____