Welcome!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Date ______ Soc. Sec. # ______ Birthdate ______

Name ______ (Last Name / First Name / Initial) Home Phone ______

Address ______ Cell Phone ______

City ______ State ______ Zip ______ E-mail ______

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer ______ Business Phone ______

Business Address ______ Occupation ______

Who should we thank for referring you? ______

In case of emergency, who should we contact? ______ Phone ______

Primary Insurance

Person Responsible for Account ______ (Last Name / First Name / Initial)

Relationship to Patient ______ Birthdate ______ Soc. Sec. # ______

Address ______ Home Phone ______

City ______ State ______ Zip ______

Responsible Party Employed By ______ Business Phone ______

Business Address ______ Occupation ______

Insurance Company ______

Insurance Company Address ______

Subscriber I.D. # ______ Group # ______

Additional Insurance

Insured Name ______ (Last Name / First Name / Initial)

Relationship to Patient ______ Birthdate ______ Soc. Sec. # ______

Address ______ Home Phone ______

City ______ State ______ Zip ______

Insured Employed By ______ Business Phone ______

Insurance Company ______

Insurance Company Address ______

Subscriber I.D. # ______ Group # ______

Dental History

Former Dentist ______________________
City, State ______________________
Date of Last Dental Visit ______________________
Date of Last X-Rays ______________________
How Often Do You Floss? ______________________
How Often Do You Brush? ______________________

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain.. ☐
- Tooth Pain ☐

Medical History

Physicianís Name ______________________ Date of Last Visit ______________

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐

Please describe: ______________________

____

	Yes	No
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

	Yes	No
Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough - persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis-Type ______ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Kidney Disease ☐
- Latex Sensitivity ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Venereal Disease ☐

Assignment and Release

I hereby authorize payment directly to ______________________ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party ______________________ Date ______________

Smiles of Waterbury

1127 West Main Street
Waterbury, CT 06708
(203)527-4614

Method of Payment

Payment is expected on the day service is provided. We will be glad to submit your insurance company: however, after 90 days if the balance is unpaid, it becomes the responsibility of the patient/insured to follow up with their insurance company.

- We accept local (CT) checks, money orders, cash and major credit cards.
- Delinquent accounts transferred to collections will be accessed a fee up to 40% of the unpaid balance.
- There is a 25$ charge for checks returned unpaid.

Broken Appointments

Missed appointments are a hardship for everyone, including the patient. Our policy requires a 24 hour notice to change or cancel an appointment. Your insurance company is not responsible nor will be billed for missed appointments. Appointments without 24 hour notice are subject to a 50$ charge and may result in termination.

Duplicate Records

Smiles of Waterbury will be glad to forward your records upon your written authorization that should include the name and address of your current dentist.

Radiographs may be forwarded at no charge to another provider. Patients requesting their own copy will be charged a nominal $25 fee to cover reproduction costs. A minimum of a 5 working days is required for this service.

____

Patient Signature Date

Smiles of Waterbury

1127 West Main Street
Waterbury, CT 06708

(203)527-4614

Informed Consent for Routine Dental Treatment

In order to provide comfortable dental treatment it is often necessary to administer local anesthesia (Novocaine, Lidocaine, etc) by injection. This is a commonly performed procedure in dental offices and usually carries very little risk. However, there are risks associated with its use.

Possible complications include but are limited to:

- Local pain or infection
- Temporary but potentionally permanent numbness or altered sensation to the nerve that goes to the lip, tongue, gum, etc.
- Systemic (whole body) reaction

Additionally, pain or prolonged discomfort to the jaw joints (TMJ) may occur from treatment. This is a known complication due to wide opening and stress on the jaw joints. Although usually temporary, discomfort and restricted jaw movements for sometime might occur.

By my signature I attest that I have read and understand this consent to local anesthesia administered as necessary and to have routine dental procedures performed. I have provided an accurate history of my medical and dental status including all medications that I am taking.

____

Patient Name Print Name (Patient) Date

____

Witness

____

Signature of Guardian (if minor)/relationship

Smiles of Waterbury

1127 West Main Street
Waterbury, CT 06078

(203)-228-8425

I hereby acknowledge receipt of HIPPA privacy regulations.

____

Signature, Date