C&W Dentistry LLC

"Dentistry from our family to yours."

Plymouth Dental Care ~Winsted Dental Care

Patient Information (Confidential)

Patient Number _____

Name _____ Date _____

SS#/SIN _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Name of School (Student) _____ City & State _____ ☐ Full Time ☐ Part Time

Employer (Patient or Student's Guardian) _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Whom May We Thank For Referring You? _____

Person To Contact In Case Of An Emergency _____ Phone _____

Responsible Party

Name Responsible For This Account _____ Relationship To Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Phone _____ SS#/SIN _____

Is This Person Currently A Patient In Our Office? ☐ Yes ☐ No

For Your Convenience, We Offer The Following Methods Of Payment. Please Check The Option You Prefer. Payment In Full At Each Appointment.

☐ Cash ☐ Personal Check Credit Card: ☐ VISA ☐ MasterCard ☐ I Wish To Discuss The Office's Payment Policy.

Insurance Information

Name Of Insured _____ Relationship To Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name Of Employer _____ Union /Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Insurance Address _____ City _____ State _____ Zip _____

How Much Is Your Deductible? _____ How Much Have You Used? _____ Max, Annual Benefit _____

Do You Have Any Additional Insurance?

Name Of Insured _____ Relationship To Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name Of Employer _____ Union /Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Insurance Address _____ City _____ State _____ Zip _____

How Much Is Your Deductible? _____ How Much Have You Used? _____ Max, Annual Benefit _____

Flip Over

Patient Medical History

Physician _____ Phone _____ Last Exam Date _____

1. Are you under medical treatment now? ☐ Yes ☐ No
2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years? ☐ Yes ☐ No
   If yes, please explain _____
3. Are you taking any medications(s) including non-prescription medicine? ☐ Yes ☐ No
   If yes, what medication(s) are you taking? _____
4. Have you ever taken Fen-Phen/Redux? ☐ Yes ☐ No
5. Have you ever taken Fosamax, Boniva, Actonel or any other cancer medications containing bisphosphonates? ☐ Yes ☐ No
6. Have you ever taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? ☐ Yes ☐ No
7. Do you use tobacco? ☐ Yes ☐ No
8. Do you use controlled substances? ☐ Yes ☐ No
9. Do you have or had any of the following?

High Blood Pressure	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Chest Pains	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Cardiac Pacemaker	☐ Yes	☐ No	Easily Winded	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Swollen Ankles	☐ Yes	☐ No	Angina	☐ Yes	☐ No	Hay Fever/Allergies	☐ Yes	☐ No
Fainting Seizures	☐ Yes	☐ No	Frequently Tired	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Epilepsy/Convulsions	☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Joint Replacement or Implant	☐ Yes	☐ No	Heart Trouble	☐ Yes	☐ No
Kidney Diabetes	☐ Yes	☐ No	Hepatitis/Jaundice	☐ Yes	☐ No	Respiratory Problems	☐ Yes	☐ No
AIDS or HIV Infection	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Thyroid Problem	☐ Yes	☐ No	Stomach Troubles/Ulcers	☐ Yes	☐ No	Other _____	☐ Yes	☐ No

10. Are you wearing contact lenses? ☐ Yes ☐ No
11. Are you allergic to or have you had any reactions to the following?
    - Local Anesthetics (e.g. Novocaine) ☐ Yes ☐ No
    - Penicillin or any other Antibiotics ☐ Yes ☐ No
    - Sulfa Drugs ☐ Yes ☐ No
    - Barbiturates ☐ Yes ☐ No
    - Iodine ☐ Yes ☐ No
    - Aspirin ☐ Yes ☐ No
    - Any Metals (e.g. nickel, mercury, etc.) ☐ Yes ☐ No
    - Latex Rubber ☐ Yes ☐ No
    - Other _____ ☐ Yes ☐ No
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ☐ Yes ☐ No
13. WOMEN ONLY:
    - Are you pregnant or think you may be pregnant? ☐ Yes ☐ No
    - Are you nursing? ☐ Yes ☐ No
    - Are you taking oral contraceptives? ☐ Yes ☐ No

Patient Dental History

Previous Dentist Practice _____ Last Exam Date _____

1. Do your gums bleed while brushing or flossing? ☐ Yes ☐ No
2. Are your teeth sensitive to hot and cold liquids/foods? ☐ Yes ☐ No
2. Are your teeth sensitive to sweet and sour liquids/foods? ☐ Yes ☐ No
4. Do you feel pain to any of your teeth? ☐ Yes ☐ No
5. Do you have any sores or lumps in or near your mouth? ☐ Yes ☐ No
6. Have you had any head, neck or jaw injuries? ☐ Yes ☐ No
7. Have youever experienced any of the following with you jaw? ☐ Yes ☐ No
   - Clicking ☐ Yes ☐ No
   - Pain (joint, side of face) ☐ Yes ☐ No
   - Difficulty in opening or closing ☐ Yes ☐ No
   - Difficulty in chewing ☐ Yes ☐ No
8. Do you have frequent headaches? ☐ Yes ☐ No
9. Do you clentch or grind your teeth? ☐ Yes ☐ No
10. Do you bite your lips or cheeks frequently? ☐ Yes ☐ No
11. Have you had any difficult extractions in the past? ☐ Yes ☐ No
12. Have you ever had any prolonged bleeding following extractions? ☐ Yes ☐ No
13. Have you ever had orthodontic treatment? ☐ Yes ☐ No
14. Do you wear dentures or partials? ☐ Yes ☐ No
    If yes, date of placement _____
13. Have you ever received oral hygiene instructions on the care of your teeth or gums? ☐ Yes ☐ No
14. Do you like your smile? ☐ Yes ☐ No

Authorization and Release: *I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I athorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less then the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.*

X _____

Signature of patient (or parent/guardian if minor)

Doctor's Comments: _____

_____ *Signature* _____ *Date* _____