**Avenue Dental Arts**
799 FARMINGTON AVENUE
WEST HARTFORD, CT 06119-1657
860-236-3271

# REGISTRATION AND HEALTH HISTORY

Date _____

_____/_____/_____/_____/ _____
PATIENT NAME — DATE OF BIRTH — NAME YOU WOULD LIKE TO BE CALLED

_____
RESIDENCE ADDRESS

_____
EMPLOYED BY OR SCHOOL ATTENDING — CITY — STATE — WORK PHONE NO.

_____
RESPONSIBLE BILLING PARTY NAME/ADDRESS — CITY — STATE — ZIPCODE

_____
DENTAL INSURANCE COMPANY NAME AND ADDRESS — CITY — STATE — ZIPCODE

_____
SUBSCRIBER'S EMPLOYER

_____
SUBSCRIBER'S NAME AND DATE OF BIRTH — SUBSCRIBER'S ID# — INSURANCE GROUP#

_____
REFERRED BY

EMERGENCY CONTACT NAME _____

EMERGENCY CONTACT PHONE # _____

APPOINTMENT REMINDERS (indicate preference):

Email _____

Cell phone (text) _____

Home phone_____

# MEDICAL INFORMATION

Please take a moment to let us know about your medical and dental history so we may serve you more effectively by understanding your overall health and well-being.

Your Primary Care Physician's Name _____

Address _____ Phone No. _____

**Please mark any of the following if they apply, and explain below:**

Are you currently under the care of a physician due to a specific condition? Y / N

_____

Have you been hospitalized within the last 5 years due to a surgery or illness? Y / N

_____

Please list any prescription or non-prescription medications? (include supplements):

Medication _____ for _____

Medication _____ for _____

Medication _____ for _____

Medication _____ for _____

Medication _____ for _____

Do you use tobacco (smoking or chewing)? Y / N

Have you ever been told to take premedication for dental treatment? Y / N

Do you experience any issue with acid reflux or GERD? Y / N

WOMEN ONLY: are you pregnant? If yes, please give due date? _____

Please indicate if you have experienced or are under treatment for any of the following:

___ Allergies to medications (Penicillin or Codeine)
___ Artificial Joints
___ Cancer
___ Diabetes
___ Glaucoma
___ Heart Murmur
___ Heart Disease
___ HIV
___ Liver Disease
___ Stroke
___ Rheumatism
___ Sinus Problems
___ Asthma
___ Epilepsy
___ Hepatitis
___ Jaundice
___ Mental Health
___ Respiratory Problems
___ Tuberculosis
___ Arthritis
___ Blood Thinners
___ High Blood Pressure
___ Kidney Disease
___ Pacemaker/Defibrillator
___ Rheumatic Fever
___ Radiation Treatment
___ Venereal Disease

Please list any other conditions, disease or allergies that we should be aware of.

_____

_____

_____

_____

_____

# DENTAL INFORMATION

What is the reason for your dental visit today? _____

_____

When was your last visit to the dentist (if to a different office)? _____

Are you in any discomfort now? Y / N

Have you had any complications following dental procedures? Y / N

When did you last have your teeth cleaned? _____

When did you last have a full mouth x-ray series? _____

When did you last have check-up x-rays? _____

When do you brush your teeth? _____

When do you floss? _____

**Please mark any of the following if they apply and explain below:**

____ Do your gums bleed when you brush or floss?
____ Are your teeth sensitive to cold or hot temperatures?
____ Are your teeth sensitive to chewing pressure?
____ Have you had adverse reactions to dental anesthetics?
____ Are you aware of grinding or clenching your teeth?
____ Do you currently have any dental implants, dentures, or partials?
____ Do you get headaches?
____ Do you experience pain in front of your ears?
____ Do you experience any jaw locking that prevents opening or closing?
____ Do you experience any clicking or popping from your jaw joint?

If you could change anything about your mouth, teeth or smile, what would it be? _____

_____

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my medical/dental health, I will inform the office at my next dental appointment without fail.

Signed: _____ Dated: _____

# AUTHORIZATION

I HEREBY CERTIFY THAT I HAVE READ AND UNDERSTAND THE PREVIOUS INFORMATION AND THAT IT IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I ACKNOWLEDGE THAT PROVIDING INCORRECT AND/OR INACCURATE INFORMATION HAS THE POTENTIAL OF BEING HAZARDOUS TO MY HEALTH.

I AUTHORIZE THE DIAGNOSIS OF MY DENTAL HEALTH BY MEANS OF RADIOGRAPHS, STUDY MODELS, PHOTOGRAPHS, OR OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE.

I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND RECORDS OF TREATMENT OF EXAMINATION FOR MYSELF AND MY DEPENDENT(S) TO THIRD-PARTY INSURANCE CARRIERS, PAYORS, AND/OR HEALTHCARE PRACTITIONERS.

I AUTHORIZE THE PAYMENT FROM MY INSURANCE CARRIER TO SUBMIT PAYMENT DIRECTLY TO THE DENTIST OR DENTAL PRACTICE TO BE APPLIED DIRECTLY TO ANY OUTSTANDING BALANCE ON MY ACCOUNT.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY OUTSTANDING BALANCE FOR SERVICES PROVIDED THAT ARE NOT FULLY COVERED BY INSURANCE, AND I MAY BE BILLED FOR THIS REMAINING BALANCE. I CONSENT AND AGREE TO BE FINANCIALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF AND OF MY DEPENDENTS (IF ANY).

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN:

SIGNATURE:_____DATE:_____

RELATIONSHIP TO PATIENT: _____