Tolland Family Dentistry

359 Merrow Road
Tolland, Connecticut 06084 **860 875 9000**

Today's Date _____ / _____ / _____

Dental History

What would you like us to do today? Are you in dental discomfort today?

Former dentist Phone

Date of last dental care Date of last x-rays

Do you have problems with any of the following:

☐ Y ☐ N **Bad breath**
☐ Y ☐ N **Grinding or clenching teeth**
☐ Y ☐ N **Periodontal treatment**
☐ Y ☐ N **Food collection between teeth**
☐ Y ☐ N **Clicking or popping jaw**
☐ Y ☐ N **Bleeding gums**
☐ Y ☐ N **Loose teeth or broken fillings**
☐ Y ☐ N **Sores or growths in mouth**
☐ Y ☐ N **Sensitivity to sweets**
☐ Y ☐ N **Sensitivity to cold**
☐ Y ☐ N **Sensitivity to biting**
☐ Y ☐ N **Sensitivity to hot**

How often do you brush?_____ Floss?_____ How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N

Medical History

Physician's name _____ Phone_____ Date of last visit _____

Have you had any serious illnesses or operations? ☐ Y ☐ N If yes, describe_____

Are you currently under physician care? ☐ Y ☐ N If yes describe _____

Have you ever had a blood transfusion? ☐ Y ☐ N If yes give approximate dates _____

Women: Are you pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N

Are you currently taking any medications? ☐ Y ☐ N If yes, list all: _____

Do you have drug allergies? ☐ Y ☐ N If yes, list all: _____

Check yes if you had any of the following:

☐ Y ☐ N Aids / HIV positive
☐ Y ☐ N Material allergies
☐ Y ☐ N Artificial Heart Valves
☐ Y ☐ N Psychiatric care
☐ Y ☐ N Back Problems
☐ Y ☐ N Heart problems
☐ Y ☐ N Rheumatic/scarlet fever
☐ Y ☐ N Circulatory problems
☐ Y ☐ N Jaw pain
☐ Y ☐ N Tobacco habit
☐ Y ☐ N Surgical implant
☐ Y ☐ N Tonsillitis
☐ Y ☐ N Liver disease
☐ Y ☐ N Arthritis, Rheumatism
☐ Y ☐ N Fainting
☐ Y ☐ N Pacemaker/heart surgery
☐ Y ☐ N Heart murmur
☐ Y ☐ N Respiratory disease
☐ Y ☐ N Chemical Dependency
☐ Y ☐ N Hepatitis (if yes, which type)
☐ Y ☐ N High blood pressure
☐ Y ☐ N Tuberculosis
☐ Y ☐ N Kidney disease
☐ Y ☐ N Anemia
☐ Y ☐ N Epilepsy
☐ Y ☐ N Nervous problems
☐ Y ☐ N Asthma
☐ Y ☐ N Headaches
☐ Y ☐ N Radiation treatment
☐ Y ☐ N Chemotherapy
☐ Y ☐ N Cancer
☐ Y ☐ N Herpes
☐ Y ☐ N Stroke
☐ Y ☐ N Tuberculosis
☐ Y ☐ N Thyroid disease or malfunction
☐ Y ☐ N Anaphylaxis
☐ Y ☐ N Diabetes
☐ Y ☐ N Mitral valve prolapse
☐ Y ☐ N Artificial joints
☐ Y ☐ N Glaucoma
☐ Y ☐ N Hemohillia/Abnormal bleeding
☐ Y ☐ N Shortness of breath
☐ Y ☐ N Cortisone treatments
☐ Y ☐ N Ulcer/colitis

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and helpful dental treatment. If there is any change in my medical status, I will inform the dentist.
I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date:_____

Payment is due in full at time of treatment, unless prior arrangements have been approved.