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

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Today's Date _____/_____/_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	Mr. Miss Mrs. Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Street Address	City	State	ZIP Code	Birth Date / /	Age	Sex M F

P.O. Box	City	State	ZIP Code	Social Security

Home Phone No. ( )	Mobile No. ( )	Email address

Occupation	Employer	Employer Phone No. ( )

Chose Clinic Because/Referred to Clinic by (Please check one box) Dr. _____ Insurance Plan Hospital

Family Friend Close to Home/Work Other _____

Other Family Members Seen Here _____

INSURANCE INFORMATION

Subscriber Name	Subscriber Birthdate	Subscriber Social Security #

Subscriber Employer	Patient relationship to subscriber

If patient is a full time college student, Name & Address of School and projected graduation date

Dental Insurance Co.	Insurance Co. Phone#

Insurance Co. Address-City-State-Zip

Subscriber ID #	Group #	Payer ID

Please ask for another form if you are covered under a secondary dental insurance plan. Thank You

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient

Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize Tolland Family Dentistry or insurance company to release any information required to process my claims.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

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.