Plantsville Dental

Thomas L. DeRienzo, D.M.D.

15 Cornerstone Court, Unit #1
Plantsville, CT 06479

Date:_____

Patient Name: _____ **Social Security #:** _____
Date of Birth: _____ **Gender:** M F **Age:** _____ **Marital Status**: _____
Address: _____ **City:** _____ **State**: _____
Home Phone #: _____ **Cell Phone #:** _____
Occupation: _____ **Work Phone #:** _____

Spouse's Name: _____ **Date of Birth:** _____
Spouse's Employer Name & Address: _____
Spouse's Occupation: _____ **Work Phone #:** _____

Who may we contact in case of emergency? _____ **Phone #**:_____

* * **How were you referred to us? _____** *** ***

IF PATIENT IS A MINOR OR STUDENT:
Responsible Party: _____ **Home Phone #:** _____
Address: _____ **Business Phone #:** _____

IF PATIENT IS A STUDENT
Name of School/College: _____ **City:** _____ **State:** _____

INSURANCE INFORMATION:
Primary Insurance: _____ **Secondary Insurance:** _____
Subscriber's Name: _____ **Subscriber's Name:** _____
Soc Sec #: _____ **D.O.B:** _____ **Soc. Sec. #:** _____
I.D #: _____ **I.D #:** _____
Employer: _____ **Employer:** _____

SIGNATURE ON FILE

AUTHORIZATION TO PAY BENEFITS:
I hereby authorize payment directly to the above named dentist of the dental benefits.

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize the above named dentist to provide any insurance companies, claim administrators and consulting health care professionals, information concerning healthcare, advice, treatment or supplies provided. This information will be issued for the purpose of evaluating and administering claims for benefits.

These authorizations are valid for the term of coverage of the policy or contract in force on this date.

Signature: _____ **Date:** _____

HEALTH HISTORY

Answer all questions by circling Yes or No

1. Are you in good health? Y N
2. Has there been any change in your health in the past year? Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problems? Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? Y N
   If so, describe _____
   _____

Do you have or have you ever had:

1. Rheumatic fever or rheumatic heart disease? Y N
2. Congenital heart disease? Y N
3. Cardiovascular disease (heart attack, heart trouble, heart murmur, coronary artery disease, angina, high blood pressure, stroke palpitations, heart surgery or pacemaker)? Y N
4. Lung disease (asthma, emphysema, COPD, chronic cough, shortness of breath, chest pain, severe coughing. Y N
5. Seizures, convulsions, epilepsy, fainting or dizziness? Y N
6. Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily? Y N
7. Liver disease (jaundice, hepatitis)? Y N
8. Kidney disease? Y N
9. Diabetes? Y N
10. Thyroid disease (goiter)? Y N
11. Arthritis? Y N
12. Stomach ulcers or colitis? Y N
13. Glaucoma? Y N
14. Osteoporosis? Y N
15. Implants placed anywhere in your body (heart valve, pacemaker, hip, knee)? Y N
16. Radiation (x-ray) treatment for cancer? Y N
17. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? Y N
18. Sinus or nasal problems? Y N
19. Any disease, drug or transplant operation that has depressed your immune system? Y N

Are you using any of the following?

1. Antibiotics? Y N
2. Anticoagulants (blood thinners) Y N
3. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
4. High blood pressure medications? Y N
5. Steroids? Y N
6. Tranquilizers? Y N
7. Insulin or oral anti-diabetic drugs? Y N
8. Heart medications? Y N
9. Are you or have you ever taken Biophosphonates for osteoporosis, multiple myeloma or other cancers (reclast, fosamax, actonel, boniva, aredia, zometa)? Y N
10. Have you ever been advised to not take a medication? Y N
11. Please list any and all medications taken, including prescription medications diet drugs, over the counter medications, herbal or holistic remedies or vitamins:
    _____
    _____

Are you allergic to or have you have an adverse reaction to:

1. Local anesthesia (novacain)? Y N
2. Penicillin or other antibiotics? Y N
3. Sedatives, barbiturates? Y N
4. Aspirin or ibuprofen? Y N
5. Codeine or other painkillers? Y N
6. Metal of any kind? Y N
7. Chemicals or jewelry? Y N
8. Food products? Y N
9. Other allergies or reactions? List them:
   _____
   _____
10. Do you smoke or chew tobacco? Y N
11. How much per day? _____
12. Is there any past history of alcohol or chemical dependency or emotional disorder may affect the care we provide for you? Y N
13. Have you had any serious problems associated with any previous dental treatment? Y N
14. Have you or an immediate family member had any problem associated with intravenous anesthesia? Y N
15. Do you have any other disease, condition or problem not listed? Y N
16. Have you ever had a bone density scan? Y N

For women only:

1. Are you pregnant, or any chance you may be? Y N
2. Are you nursing? Y N

* If you are using oral contraceptives, it is important that you understand that some antibiotics may interfere with the effectiveness of oral contraceptives.

Date: _____ Signature _____ Dr's Initials _____