BRUSH & FLOSS
DENTAL CENTER
GENERAL, COSMETIC AND IMPLANT DENTISTRY
(203) 378-9500

WELCOME TO YOUR DENTAL OFFICE

PATIENT INFORMATION

DATE _____

Patient's Name _____
Mr. Mrs. Ms. Dr. Last First Middle Initial

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Business Phone _____

Cell Phone _____ E-Mail Address _____

Date of Birth _____ Social Security Number (for insurance) _____

Marital Status: Single Married Separated Divorced Widowed

Student Status (if 19 years or older): Full Time Part Time Not a Student

Name of College or University _____

Whom May We Thank For Referring You _____

DENTAL INSURANCE - POLICY HOLDER INFORMATION

Primary Policyholder's Name _____

Primary Policyholder's Address _____

Name of Dental Insurance Company _____

Address of Dental Insurance Company _____

Employer's Name _____

Employer's Address _____

Group # _____ Social Security # of Policyholder _____

Date of Birth of Policyholder _____ Relationship to Patient: SELF SPOUSE PARENT OTHER

Secondary Policyholder's Name _____

Secondary Policyholder's Address _____

Name of Dental Insurance Company _____

Address of Dental Insurance Company _____

Employer's Name _____

Employer's Address _____

Group # _____ Social Security # of Policyholder _____

Date of Birth of Policyholder _____ Relationship to Patient: SELF SPOUSE PARENT OTHER

MEDICAL HISTORY

Do you have a personal physician? YES NO

Physician's Name: Dr. _____

Address: _____

Phone # _____ Date of last visit _____

Your current physical health is: GOOD FAIR POOR

Are you currently under the care of a physician: YES NO

If yes, please explain: _____

_____

Do you smoke or use tobacco in any other form? YES NO

Have you ever taken Fen-Phen, Redux or Pondimin? YES NO

FOR WOMEN: Are you taking birth control pills? YES NO

Are you currently pregnant? YES NO UNSURE

Week # _____ Are you nursing? YES NO

Are you taking: Boniva Fosomax Actonel Evista

PLEASE LIST ANY SERIOUS MEDICAL CONDITION(S) THAT YOU HAVE EXPERIENCED:

_____ _____

_____ _____

ARE YOU TAKING ANY PRESCRIPTION, OVER-THE-COUNTER DRUGS, HERBAL REMEDIES, VITAMINS? PLEASE LIST EACH:

_____ _____

_____ _____

Why have you come to our office? _____

Are your teeth sensitive to heat, cold or anything else? YES NO

Are you currently in pain? YES NO

Do you require antibiotics before dental treatment? YES NO

Do you still have your wisdom teeth? YES NO

Date of your last dental visit? _____

Your current dental health is? GOOD FAIR POOR

Do you floss daily? YES NO

Do your gums ever bleed? YES NO

Have you ever had periodontal disease? YES NO

Do you have mobility in your teeth? YES NO

Would you like fresher breath? YES NO

Would you like whiter teeth? YES NO

Are you happy with the way your smile looks? YES NO

If not, what would you change? _____

DO YOU HAVE OR HAVE YOU EXPERIENCED THE FOLLOWING? (PLEASE CIRCLE THOSE THAT APPLY)

ABNORMAL BLEEDING
ALCOHOL ABUSE
ANEMIA
ARTHRITIS
ARTIFICIAL BONES/JOINTS
ASTHMA
BLOOD TRANSFUSION
BONE MARROW TRANSPLANT
CANCER
CHEMOTHERAPY
COLITIS
CONGENITAL HEART DEFECT
DIABETES
DIFFICULTY BREATHING
DIZZINESS
DRUG ABUSE
EMPHYSEMA
EPILESPY/SEIZURES
EVER HOSPITALIZED
FAINTING SPELLS
FEVER BLISTERS
GLAUCOMA
HAY FEVER
HEADACHES
HEART ATTACK
HEART MURMUR
VENEREAL DISEASE
HEART SURGERY
HEMOPHILIA
HEPATITIS
HERPES
HIGH BLOOD PRESSURE
HIV/AIDS
KIDNEY PROBLEMS
LIVER DISEASE
LOW BLOOD PRESSURE
LUPUS
MITRAL VALVE PROLAPSE
PACEMAKER
PERSISTENT COUGH
PSYCHIATRIC PROBLEMS
RADIATION TREATMENT
RHEUMATIC FEVER
SCARLET FEVER
SHINGLES
SICKLE CELL DISEASE
SINUS PROBLEMS
STEROID THERAPY
STROKE
THYROID PROBLEMS
TONSILITIS
TUBERCULOSIS (TB)
ULCERS

Are you allergic to any of the following?
(Please circle any that apply)

ASPIRIN
BARBITURATES
CODEINE
DENTAL ANESTHETICS
ERYTHROMYCIN
JEWELRY/METALS
LATEX
PENICILLIN
SEDATIVES
SULFA DRUGS
TETRACYCLINE
OTHER _____

_____

STATEMENT OF FINANCIAL RESPONSIBILITY

- In order to control your cost of billings, we request that our charges for treatment provided be paid at the conclusion of each visit.
- Please remember that insurance is considered a method of reimbursing the patient for fees paid to the dentist and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balances not paid by your insurance company.
- If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and cost of collection.
- I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

RESPONSIBLE PARTY INFORMATION

Please complete the information below if the person responsible for paying the bill is NOT the PATIENT

Responsible Party's Name _____
Last First Middle Initial

Responsible Party's Address _____

_____

Telephone # _____
Home Work Cell

Social Security # _____

Employer's Name _____

Employer's Address _____

_____

Relationship to Patient: Spouse Parent Guardian Other _____

I AGREE THAT ANY PHOTOGRAPHS TAKEN OF MY DENTISTRY MAY BE USED FOR EDUCATIONAL PURPOSES.

I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES SHOWN ON THE FORM. I HAVE READ THE TERMS CAREFULLY.

Signature Required X _____ Date _____