# AAA DENTAL CARE

## *Patient Information*

550 Summer Street, 2nd Floor
Stamford, CT 06901
(203) 663-3737
AAADentalStamford.com

Circle One: Dr/Mr/Mrs/Ms/Miss
First: _____Middle: _____ Last: _____Jr/Sr: _____
Street: _____ City: _____ State:_____ Zip:_____
Home Phone: _____Work Phone: _____
Cell Phone: _____
Email Address: _____
Patient Social Security Number:_____ Patient Date of Birth: _____Sex: (circle) **M** **F**
Emergency Contact:_____ Phone: _____
Preferred Pharmacy_____
How did you hear about us?
☐Google ☐Yelp ☐ZocDoc ☐Facebook ☐Insurance ☐Family/Friend ☐Other: _____

### Insurance Information

Do you have Dental Insurance? (circle) **Yes No** Do you have Secondary Dental Insurance? (circle) **Yes No**

| **Primary Insured** | | **Secondary Insured** | |
|---|---|---|---|
| Subscriber Name | | Subscriber Name | |
| Subscriber SSN | | Subscriber SSN | |
| Date of Birth | | Date of Birth | |
| Relationship to Subscriber | ☐Self ☐Spouse ☐Child ☐Other | Relationship to Subscriber | ☐Self ☐Spouse ☐Child ☐Other |
| Employer Name | | Employer Name | |
| Employer Phone | | Employer Phone | |
| Insurance Company | | Insurance Company | |
| Insurance Group # | | Insurance Group # | |
| Insurance Phone # | | Insurance Phone # | |
| ***Please present your insurance card to our patient services representative to be photocopied*** | | | |

**1. Payment, Insurance, and Financial Arrangement Policies (must be signed by ALL new patients).**

By signing below, I acknowledge that I received the Financial Policies form and agree to abide by such policies.

Signature_____Date_____

**2. Notice of Privacy Practices (must be signed by ALL new patients).**

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature_____Date_____

**3. Consent to obtain patient medication history.**

To the extent permitted by applicable law, I authorize this dental practice (or their designees) to collect information about my prescription history from my pharmacy and insurers (as applicable) and give my pharmacy and insurers permission to disclose such information. This includes prescription information related to medicines to treat AIDS/ HIV and medicines used to treat mental health issues.

Signature_____Date_____

# AAA DENTAL CARE

## *Health Information*

550 Summer Street, 2nd Floor
Stamford, CT 06901
(203) 663-3737
AAADentalStamford.com

We take your oral health very seriously. But before we start your treatment, we need some brief information on your medical history which may affect your treatment. All information is confidential.

Patient's Name: _____Date of Birth: _____Last Physical Date: _____

Physician's Name & Phone #: _____Reason for today's visit? _____

Work Related Injury? (circle) **Yes No** Have you been under the care of a physician? (circle) **Yes No**

Have you ever been hospitalized? (circle) **Yes No**

Height: _____Weight: _____

Date of last dental visit:_____Date of last dental x-rays:_____Date of last cleaning:_____

Have you ever been treated for periodontal (gum) disease? (circle) **Yes No**

Ever had Novocaine or other local anesthetic? (circle) **Yes No**

Are you interested in tooth whitening? (circle) **Yes No**

If wearing dentures, age of dentures: _____Are you interested in new dentures? (circle) **Yes No**

Are you taking or have taken any steroid/cortisone therapy in the last 2 years? (circle) **Yes No**

Are you taking or have taken Oral Bisphosphonates?(e.g., FOSAMAX, ACTONEL, BONIVA, or IV Bisphosphonates, (e.g., ZOMETA, AREDIA) (circle) **Yes No** Taken for how long? _____

Have you taken antibiotics prior to dental procedures in the past? (circle) **Yes No**

Have you ever had an adverse reaction or become ill after taking penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? (circle) **Yes No**

List any medications you are **ALLERGIC** to:

1. _____ 2. _____ 3. _____ 4. _____

List any medications you are taking including non-prescription drugs and herbals/vitamins:

1. _____ 2. _____ 3. _____ 4. _____

| Do you have a history of: | Y | N | | Y | N | | Y | N | | Y | N |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Rheumatic Fever | | | Asthma | | | Thyroid Disease | | | Alcoholism | | |
| Heart Murmur | | | Allergies or Hives | | | Epilepsy or Seizures | | | Psychiatric Treatment | | |
| Mitral Valve Prolapse | | | Anemia | | | Fainting or Dizzy Spells | | | Mouth sores/growths | | |
| Diabetes | | | Teeth Grinding/Clenching | | | Pace Maker/Heart Surgery | | | Aspirin/Anticoagulant Therapy | | |
| Venereal Disease | | | Arthritis | | | Pain in your jaw (TMJ) | | | Ulcers or Stomach Problems | | |
| High Blood Pressure | | | HIV Positive/AIDS | | | Latex Allergy | | | Any type of Implant | | |
| Low Blood Pressure | | | Blood Transfusion | | | Sinus Problems | | | Cancer (Type: ) | | |
| Any type of Transplant | | | Heart Problem ( ) | | | Excessive Bleeding | | | Any Artificial Hip, Knee or other Joint | | |
| Drug Addiction | | | Dialysis | | | Stroke | | | Other Disease or Illness: | | |
| Hepatitis (Type: ) | | | Chemotherapy | | | Lung Disease | | | | | |
| Liver Disease | | | Radiation Treatment | | | Breathing Problems | | | | | |
| Kidney Disease | | | Use of Tobacco Products | | | Tuberculosis (TB) | | | | | |

| Women patients only: | Y | N | | Y | N |
|---|---|---|---|---|---|
| Is there a possibility of pregnancy? | | | Are you nursing? | | |
| Estimated Delivery Date: / / | | | Are you taking any birth control prescriptions? | | |

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature_____Date_____Dr's. Signature/Medical History Review_____Date_____

**6 MONTH UPDATE** → Patient's Signature_____Date_____Dr's. Signature/Medical History Review_____Date_____