Litchfield Dental Associates, LLC

Steven Sideris, D.D.S.
David Ritter, D.D.S.
Bradford Pinkos, D.M.D.
63 West Street, Litchfield, CT 06759
860-567-9488
litchfielddental@sbcglobal.net
www.stevensiderisdds.com

PATIENT INFORMATION

NAME	BIRTHDATE	HOME PHONE	
ADDRESS			
CITY	STATE	ZIP	
EMAIL	CELL PHONE		
○ MINOR ○ SINGLE ○ MARRIED ○ DIVORCED ○ WIDOWED ○ SEPARATED			
IF STUDENT, NAME OF SCHOOL	CITY	STATE	○FULL TIME ○PART TIME
PATIENT/PARENT/GUARDIAN EMPLOYER	WORK PHONE		
BUSINESS ADDRESS			
CITY	STATE	ZIP	
SPOUSE NAME	EMPLOYER	WORK PHONE	
WHOM MAY WE THANK FOR REFERRING YOU?			
PERSON TO CONTACT IN CASE OF EMERGENCY?	PHONE		

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT		RELATIONSHIP TO PATIENT
ADDRESS		
CITY	STATE	ZIP
HOME PHONE	CELL PHONE	WORK PHONE
EMAIL		BIRTHDATE
IS THIS PERSON CURRENTLY A PATIENT IS OUR OFFICE? ○ YES ○ NO		

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY	
GROUP NUMBER	ID NUMBER
SUBSRIBER	EMPLOYER
BIRTHDATE	SS#
RELATIONSHIP TO PATIENT: ○ SELF ○ SPOUSE ○ PARENT ○ OTHER _____	
OTHER PATIENTS COVERED BY THIS INSURANCE : _____	

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY	
GROUP NUMBER	ID NUMBER
SUBSRIBER	EMPLOYER
BIRTHDATE	SS#
RELATIONSHIP TO PATIENT: ○ SELF ○ SPOUSE ○ PARENT ○ OTHER _____	
OTHER PATIENTS COVERED BY THIS INSURANCE : _____	

HEALTH HISTORY FORM

As required by law, our office adheres to written polices and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health, This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Height	Weight	○ Male ○ Female ○Other
Are you completing this form for someone else? ○ Yes ○ No Name	Relationship	

Do you have any of the following diseases or problems: (Check (DK if you Don't Know the answer to the questions)

	Yes	No	DK
Active Tuberculosis			
Persistent cough greater than a 3 week duration			
Cough that produces blood			
Been exposed to anyone with tuberculosis			

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

DENTAL INFORMATION

For the following questions, please mark (X) your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?				Do you have earaches or neck pains?			
Are your teeth sensitive to cold, hot, sweets, or pressure?				Do you have any clicking popping or discomfort in the jaw?			
Is your mouth dry?				Do you brux or grind your teeth?			
Have you had any periodontal (gum) treatments?				Do you have sores or ulcers in your mouth?			
Have you ever had orthodontic (braces) treatment?				Do you wear dentures or partials?			
Have you had any problems associated with previous dental treatment?				Do you participate in active recreational activities?			
Is your home water supply fluoridated?				Have you ever had a serious injury to your head or mouth?			
Do you drink bottled of filtered water? If yes, how often?				Are you currently experiencing dental pain or discomfort?			
What is the reason for your dental visit today?							
How do you feel about your smile?							
Date of your last dental exam:							
What was done at that time?							
Date of last dental x-rays:							

MEDICAL INFORMATION

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician? Physician Name: Address: City: State: Zip: Phone:				Have you had a serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem?			
Are you in good health?				Are you taking or have you recently taken any prescription or over the counter medicine(s)?			
Has there been any changes in your general health within the past year? If yes, what condition id being treated?				If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:			
Date of last physical exam:				Do you use controlled substances (drugs)?			
Do you wear contact lenses?				Do you use tobacco (smoking, snuff, chew, bidis)? If so, how interested are you in stopping?			
Joint replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date If yes, have you had any complications?				Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours? If yes, how much do you typically drink in a week?			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease?				WOMEN ONLY Are you pregnant? Number of weeks?			
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal				WOMEN ONLY Are you taking birth control pills or hormonal replacement?			

complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Date treatment began?							
Artificial (prosthetic) heart valve				WOMEN ONLY Are you nursing?			
Previous infective endocarditis				Autoimmune disease			
Damaged valves in transplanted heart				Rheumatoid arthritis			
Unrepaired, cyanotic congenital heart disease (CHD)				Systemic lupus erythematosus			
Repaired (completely) in last 6 months CHD				Asthma			
Repaired CHD with residual defects				Bronchitis			
Cardiovascular disease				Emphysema			
Angina				Sinus trouble			
Arteriosclerosis				Tuberculosis			
Congestive heart failure				Cancer/chemotherapy/radiation treatment			
Damaged heart valves				Chest pain upon exertion			
Heart attack				Chronic pain			
Heart murmur				Diabetes Type I or II			
Low blood pressure				Eating disorder			
High blood pressure				Malnutrition			
Other congenital heart defects				Gastrointestinal disease			
Mitral valve prolapse				GE reflux/persistent heartburn			
Pacemaker				Ulcers			
Rheumatic fever				Thyroid problems			
Rheumatic heart disease				Stroke			
Abnormal bleeding				Glaucoma			
Anemia				Hepatitis, jaundice or liver disease			
Blood transfusion If yes, date				Epilepsy			
Hemophilia				Fainting spells or seizures			
AIDS or HIV infection				Neurological disorders If yes, specify			
Arthritis				Sleep disorder			
Osteoporosis				Do you snore?			
Persistent swollen glands in neck				Mental health disorders Specify			
Sever headaches/migraines				Recurrent infections Type of infection			
Severe or rapid weight loss				Kidney problems			
Sexually transmitted disease				Night sweats			
Excessive urination							
Allergies. Are you allergic to have you had a reaction to: (specify type of reaction)							
Local anesthetics				Latex (rubber)			
Aspirin				Iodine			
Penicillin or other antibiotics				Hay fever (seasonal)			
Barbiturates, sedatives, or sleeping pills				Animals			
Sulfa drugs				Food			
Codeine or other narcotics				Other			
Metals							
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Name of physician or dentist making recommendation:							
Do you have any disease, condition, or problem not listed above that you think I should know about?							

Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff responsible for any action they take or do not take because of errors or omissions that I may have made int the completion of this form.

Signature of
Patient/Legal Guardian:_____Date_____

Signature of Dentist:_____