Welcome To Village Dental of Milford

Patient Information

Name _____
Name Preference? _____
Address _____
City/St/Zip _____
How long at current address? _____

Birth Date: ____/____/____ Age: ____

Phone: (____)_____- _____
Cell phone _____
e-mail: _____

☐ Single ☐ Married ☐ Other
☐ Male ☐ Female

SS# _____/_____/_____
Employer: _____
Employer Phone: (____) _____-_____
How did you hear about us?

Insurance

Subscriber:_____
Address: _____
_____
(if different than Patient)
SS#: _____
Insurance ID# _____
Birth Date: _____/_____/_____
Employer: _____
Ins. Company: _____
Group/Policy#_____
Ins. Phone (_____) _____-_____

Secondary Subscriber: _____
SS#_____
Birth Date: _____/_____/_____
Employer: _____
Insurance Company: _____
Relationship to patient:

Please Check All That Apply to You:

Concerning your teeth:
_____ Tooth Pain
_____ Sensitivity
_____ Mouth Sores
_____ Broken or Chipped
_____ Fillings loose or missing
_____ Crooked or Discolored
_____ Grinding or clenching
_____ Missing teeth
_____ Bleeding, sore or irritated gums
_____ Jaw Pain
_____ Bad odors or tastes from your mouth

Do you smoke? _____
Use chewing tobacco? _____

Former Dentist_____
Phone: _____

Past Dental History

Date of last exam: _____
Have you been treated for Periodontal condition?
_____
Date of last x-rays: _____

Today's Visit

Oral exam and/or teeth cleaning _____
Tooth ache (please explain): _____
_____
Other: _____

☐ Information/options re: _____
_____ Implants
_____ Whitening
_____ Pain relief
_____ Restorations
_____ Periodontal Disease
_____ Oral conscious sedation

Medical History

Has there been any problems in your general health within the past five years? _____
If yes, please state the condition: _____
Physician treating you: _____ Phone: _____

What medicines, pills or liquids do you take? (including aspirin, vitamins, tonics, ect.)

_____

_____

Are you currently taking or have you ever been prescribed medication for Osteoporosis?_____
Has your blood pressure been checked recently? ____/____ (approx.) _____
Do you snore, or have you ever been told you snore? _____

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

- ☐ Antibiotics
- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Metals
- ☐ Novocaine
- ☐ Penicillin
- ☐ Plastic
- ☐ Sedatives
- ☐ Sleeping Pills
- ☐ Sulfa Drugs
- ☐ Other _____

MEDICAL HISTORY:

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joint or Prosthetic
- ☐ Asthma
- ☐ Bleeding Easily After a Cut
- ☐ Cancer
- ☐ Chronic Mouth Dryness
- ☐ Currently Pregnant
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Problems
- ☐ Dizziness
- ☐ Epilepsy or Seizures
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Valve Replace
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/Aids
- ☐ Injury to
  - ▭ Face
  - ▭ Mouth
  - ▭ Neck
  - ▭ Teeth
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Low Blood Pressure
- ☐ Osteoporosis
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Other _____

DESCRIBE ANY SERIOUS ILLNESS, MAJOR SURGERY OR CONDITIONS NOT LISTED ABOVE:

mm/yy: _____/_____ _____
mm/yy: _____/_____ _____
mm/yy: _____/_____ _____

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Signed _____ Date _____/_____/_____
If minor, signed by (parent or guardian please print name) _____