***Tam Le, DMD***
***Hamden Family Dental Center, LLC***
***4193 Whitney Avenue, Hamden, CT 06518***
***203.248.4080***

**Today's Date:** ______________

## Patient Information

Patient Name: ______________________________________________ Gender: ☐ M ☐ F
Last First MI

Social Security #: ____________________ Date of Birth: __________ Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Child

Phone (Home): ____________ (Work): ____________ Ext: ________ **(Cell)*:** ______________

**E-Mail*:** ______________________________ *** we send text/email appointment confirmations/reminders**

Address: ______________________________________________
Street Apartment #
______________________________________________
City State Zip Code

Responsible Party: ______________________________________________
(If different than above) Name Address Phone
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other __________

## HEALTH INFORMATION

**Have you ever had any of the following? Please check those that apply: If NONE, please check here ☐**

☐ **Artificial Heart Valve**
☐ Previous Infective Endocarditis
☐ Congenital Heart Disease
☐ Cardiovascular Disease
☐ Angina
☐ **History of Heart Attack**
☐ Heart Murmur
☐ **High Blood Pressure**
☐ **Low Blood Pressure**
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Rheumatic Fever/Heart Disease
☐ Abnormal bleeding
☐ **Anemia**
☐ Blood Transfusion
If yes, date:_________

☐ **AIDS/ HIV Infection**
☐ Arthritis
☐ **Autoimmune Disease**
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Tuberculosis
☐ **Cancer/Chemo/ Radiation**
Type/date:_______________
☐ **Joint Replacement**
Type/date:_______________
☐ Chronic Pain
☐ **Diabetes Type I or II**
☐ Eating Disorder
☐ Gastrointestinal Disease
☐ Reflux / persistent heartburn

☐ Ulcers
☐ Thyroid Problems
☐ Stroke
☐ Hepatitis/ Jaundice or Liver Disease
☐ Epilepsy
☐ **Neurological Disorders**
If yes, specify____________
☐ Sleep Disorder/Sleep Apnea
☐ **Mental Health Disorders**
If yes, specify____________
☐ Recurrent Infections
☐ Kidney Problems
☐ Osteoporosis *(#3)
☐ Headaches/ Migraines
☐ Sexually Transmitted Disease
☐ **Hemophilia**

List ALL Allergies ☐ NONE
____________________
____________________
____________________

List ALL Medications ☐ NONE
____________________
____________________
____________________
____________________
____________________

**WOMEN ONLY** Are you:
Pregnant? ☐ Yes ☐ No
Number of weeks: ________

**Do you snore?** ☐ Yes ☐ No
**Do you have a history of substance abuse/currently using?** ☐ Yes ☐ No
**Do you have a history of/use tobacco/nicotine products (smoking, snuff, chew, bidis)?** ☐ Yes ☐ No

1. Has your physician ever recommended that you take an antibiotic prior to dental treatment? ☐ Yes ☐ No

2. Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: ______________________________________________

3. Are you taking, have taken, or are scheduled to begin taking an antiresorptive agent (example: Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's Disease ☐ Yes ☐ No If yes, Date(s) taken: ____________________

4. Date of last dental visit: __________ Reason(s) for your visit today: ______________________________
Have you ever had any complications following dental treatment? ☐ Yes ☐ No If yes, please explain:
______________________________________________

5. Have you been admitted to a hospital or needed emergency care during the past five years? ☐ Yes ☐ No
If yes, please explain: ______________________________________________

6. Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain:______________________________________________

Name of Physician: ______________________________ Phone: ______________

**Preferred Pharmacy:** ____________________**Location:** ____________________ **Phone Number:**__________

## Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________________ Occupation: ______________________________

Address: ____________________________________________________________
Street City State Zip Code Phone

**Name of Emergency Contact NOT living with you**: ____________ Relationship: ________ Phone: __________

***New Patients:***
**Name of person responsible for your referral to us:** ____________ Relationship: ______________

## Insurance Information

***(New Patients: please fill in completely. Existing Patients: please update if any changes.)***

**Primary**

**Insurance Company Name and Address**: ____________________________________________

Subscriber ______________________________ Is the subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Date of Birth: __________ ID #: ____________ Group #: ______________

Address: ____________________________________________
Street City State Zip Code

Subscriber's Employer Name: ____________________________________________

Address: ____________________________________________
Street City State Zip Code

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

**Secondary**

**Insurance Company:** ____________________________________________
Name Address Phone Number

Subscriber: ______________________________ Is the subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Date of Birth: __________ ID #: ____________ Group #: ______________

Address: ____________________________________________
Street City State Zip Code

Subscriber's Employer Name: ____________________________________________

Address: ____________________________________________
Street City State Zip Code

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

I understand my insurance may downgrade to an amalgam filling and that I will be responsible for the balance due for the difference of the composite filling. Date: _________ Patient Initials: _________

## Consent for Services

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail, I hereby authorize payment directly to the doctor of medical benefits otherwise payable to me. I hereby authorize my physician to release any information required to support my claim.

**I understand that I am personally responsible to the doctor for all charges for professional services and agree to pay co-payment at time of my appointment. If balance is not paid in full within 30 days, my account will be subject to 18.00% annual finance charge (1.5% per month.) If I fail to pay my account balance for services rendered within a reasonable time period (as determined by office policy), I will be subject to collections. I am also responsible for any costs accrued in this process including small claims court costs, attorney's fees, and any collection fees, as well as the full balance on my account.**

**If unable to keep appointment, kindly give 48 hours notice. We reserve the right to charge a $75 fee for time scheduled.**

I have read the above conditions of treatment and payment and agree to their content.

**X**______________________________ Date: __________ Relationship to Patient: ____________
Signature of Patient, Parent, Guardian or Responsible Party

**Office Use Only: Hygienist Reviewed:** ______________ **Front Office Reviewed:** ______________
**Premed: Y / N**