West Main Family Dentistry
1147 West Main Street
Waterbury, CT 06708
(203) 755-5641

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Address: _____
Street Apartment #

_____
City State Zip Code

Social Security #: _____ Birth Date:_____ Driver's License #:_____

Phone (Cell): _____ (Home): _____ (Work): _____

Email:

Emergency Contact:
Name_____Phone_____Relationship to patient:_____

Health Information

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS / HIV+
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers

ALLERGIES to food and/or medications:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

- Do you or have you ever smoked cigarettes? ☐ Yes ☐ No
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Primacy Care Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

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.

_____ **Date:** _____
Signature of patient, parent or guardian

Insurance / Responsible Party Information

☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Address: _____
Street Apartment #

_____
City State Zip Code

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Referral Information

Whom may we thank for referring you to our practice?
☐Another patient, friend ☐Another patient, relative ☐ Dental Office ☐ Online ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice:

Consent for Services

I hereby authorize and direct the dentist and/or dental auxillaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.
I understand x-rays, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors, but copies of certain aids are available upon request for a fee.
In general terms, the dental procedure(s) can include but are not limited to: 1) Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of topical fluoride 2) Application of resin "sealants" to the grooves of the teeth. 3) Treatment of diseased or injured teeth with dental restorations (fillings) 4) Treatment of diseased or injured oral tissue secondary to traumatic injuries and/or accidents and/or infections.
I understand the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service.

- I certify that I, and/or my dependent(s), have insurance coverage with the above named Insurance Company and assign directly to West Main Family Dentistry all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
West Main Family Dentistry may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will stay in effect as long as I am a patient of the above named dental practice.

- I certify that I, and/or my dependent(s) do not have insurance coverage. I understand I am financially responsible for all charges and those fees are to be paid in full at the time of service.

For your convenience, we accept Master Card, Visa, Discover, American Express, and CareCredit.
If this account is assigned to a collection agency for unpaid collections and/or suits, I/we will be responsible for costs for the agency and/or reasonable attorney's fees.

I hereby acknowledge that I have read and understood this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

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

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Medication List

☐ Not taking any medications
List below all of your current medications including over the counter

New medications or medication changes should be added to the list.

Medication Name	Reason For Medication	Dosage/ Frequency

Do you need to premedicate prior to dental procedures?

☐ Yes ☐ No

- Reason for premedication: _____
- How long do you have to premedicate (per your MD):_____
- What antibiotic do you take as premedication? _____
- Preferred Pharmacy: Name_____ Phone_____
  Address: _____