Ira M. Greene, D.D.S.
Pediatric Dentistry
Avondale Medical Center
34 Dale Rd., Avon, CT 06001
phone: (860) 674-0874 fax: (860) 674-8716

New Patient Form

Today's Date:

1 TELL US ABOUT YOURSELF

Name: _____
Last First Middle

Address: _____

_____
City State Zip

SSN: _____ DL#: _____

☐ Male ☐ Female Age: _____ Birthdate: ____/____/____

☐ Single ☐ Married ☐ Widowed ☐ Seperated ☐ Divorced

Occupation: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

Employer's Phone #: (____) _____

Spouse's Name: _____
Last First Middle

SSN: _____ Birthdate: ____/____/____

Occupation: _____

Spouse's Employer: _____

Are they any other issues associated with receiving dental care?

_____

2 WHO MAY WE THANK FOR REFERRING YOU?

_____

3 CONTACT INFORMATION

Mobile Phone: (____) _____

Other Phone: (____) _____

Email: _____

It is best to communicate through: ☐ Text ☐ Email

In case of emergency, contact:

Name: _____
Last First Middle

Relationship: _____

Mobile Phone: (____) _____

Other Phone: (____) _____

4 PRIMARY DENTAL INSURANCE

Who is responsible for this account? _____

Relationship: _____

SSN: _____ DL#: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____

SSN: _____

Policy Owner's Employer: _____

5 SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____

SSN: _____

Policy Owner's Employer: _____

6 ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

7 DENTAL HISTORY

Reason for today's visit: _____

Former dentist's name: _____

Phone #: (____) _____

Date of last dental visit: _____

Date of last dental X-rays: _____

Please circle if you have the following:

Y N Bad breath
Y N Bleeding gums
Y N Blisters on lips or mouth
Y N Broken fillings
Y N Burning sensation on tongue
Y N Chew on one side of mouth
Y N Cigarette, pipe, or cigar smoking
Y N Clicking or popping jaw
Y N Dry mouth
Y N Fingernail biting
Y N Food collection between the teeth
Y N Foreign objects
Y N Grinding teeth
Y N Gums swollen or tender
Y N Jaw pain or tiredness
Y N Lip or cheek biting
Y N Loose teeth
Y N Mouth breathing
Y N Mouth pain, brushing
Y N Nitrous oxide
Y N Orthodontic treatment
Y N Pain around ear
Y N Peridontal treatment
Y N Sensitivity to cold
Y N Sensitivity to heat
Y N Sensitivity to sweets
Y N Sensitivity when biting
Y N Sores or growths in mouth

How often do you floss? _____

How often do you brush? _____

Do you like your smile? Y N

8 HEALTH HISTORY

Physician: _____

Phone #: (____) _____

Date of last visit: _____

Are you currently under the care of a physician? YES NO

If yes, please explain: _____

Does your physician require pre-medication prior to dental treatment? YES NO

Have you had any serious illness, operations, or hospitalizations? YES NO

Please circle if you have the following:

Y N AIDS/HIV
Y N Anemia
Y N Arthritis, Rheumatism
Y N Artificial heart valves
Y N Artificial joints
Y N Asthma
Y N Back problems
Y N Bleeding abnormally, with extractions or surgery
Y N Blood disease
Y N Cancer
Y N Chemical dependency
Y N Chemotherapy
Y N Circulatory problems
Y N Congenital heart disorder
Y N Contact lenses
Y N Cortisone treatments
Y N Cough, persistent or bloody
Y N Dementia/Alzheimer's
Y N Developmental Disabilities
Y N Diabetes
Y N Emphysema
Y N Epilepsy
Y N Fainting or dizziness
Y N Glaucoma
Y N G.E. Reflux/ Heartburn
Y N Headaches
Y N Heart murmur
Y N Heart problems
Y N Hepatitis type
Y N Herpes
Y N High blood pressure
Y N Immune deficiency
Y N Psychiatric care
Y N Organ transplant
Y N Osteoporosis
Y N Osteopenia
Y N Radiation treatment
Y N Respiratory disease
Y N Rheumatic fever
Y N Scarlet fever
Y N Shortness of breath
Y N Sinus trouble
Y N Sickle cell anemia
Y N Skin rash
Y N Special diet
Y N Stroke
Y N Swollen feet/ankles
Y N Swollen neck glands
Y N Thyroid problems
Y N Tonsillitis
Y N Tuberculosis
Y N Tumor or growth on head/neck
Y N Ulcers
Y N Venereal disease
Y N Weight loss, unexplained

Women:

Are you pregnant? YES NO

Due date: _____

Taking birth controll pills? YES NO

Are you nursing? YES NO

Social Information:

Do you use tobacco? YES NO

Quanity _____ Per Day _____ Per Week

9 MEDICATIONS

List any medications that you are taking (prescriptions, over the counter or herbal):

_____

_____

_____

Pharmacy Name: _____

Phone #: (____) _____

Circle if you are allergic to the following:

Y N Aspirin
Y N Barbituates (Sleeping pills)
Y N Codeine
Y N Iodine
Y N Latex
Y N Dental Anesthetic
Y N Penicillin
Y N Sulfa
Y N Other _____

10 AUTHORIZATION AND RELEASE

I hereby certify that I have read the foregoing and filled out this questionnaire completely. I have advised you of all medical problems of which I am aware of.

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Responsible Party Signature	Relationship	Date