Center for
Dental Excellence, LLC
625 Hopmeadow Street
Simsbury, CT 06070
Phone (860) 658-1991
Fax (860) 651-0624
www.CTCDE.com

Date _____

Dr., Mr., Mrs., Miss _____ Birthdate _____
Last First Middle

Guardian's name, if patient is a minor _____

Residence address _____ E-mail: _____
Number Street

_____ Phone _____
City State Zip

Occupation _____ Employer _____ Years _____ Soc. Sec.# _____

Business address _____ Phone _____
Employer City

Marital status _____ Spouse's Name _____ Soc. Sec.# _____

Spouse's employer _____ Spouse's Birthdate _____
Name of employer Address

Dental Insurance: Primary ID#_____ Secondary ID# _____

MEDICAL HEALTH

Referred By _____

It is important that we know about your dental and medical history. Many things have a direct bearing on your dental health. We will review the questionnaire and discuss it with you in detail. Information you give us is strictly confidential and will not be released to anyone without your written permission.

Name and address of physician _____

_____

Last complete physical? _____

Are you taking any medications now? Yes ☐ No ☐ For what purpose? _____

Do you premedicate for dental appts? Yes ☐ No ☐ Name of medication & dosage _____

Have you ever been treated for:

Heart disease	Yes ☐	No ☐	Hip or joint replacements	Yes ☐	No ☐
Rheumatic fever	Yes ☐	No ☐	Heart murmur	Yes ☐	No ☐
Abnormal blood pressure	Yes ☐	No ☐	Jaundice	Yes ☐	No ☐
Ulcers	Yes ☐	No ☐	Asthma or hay fever	Yes ☐	No ☐
Tuberculosis or lung disease	Yes ☐	No ☐	Sinus trouble	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Contact lenses	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	HIV, Aids	Yes ☐	No ☐
Congenital heart lesions	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Psychiatric care	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
			Glaucoma	Yes ☐	No ☐

Have you ever been treated (other than diagnostic) with x-ray? ..... Yes ☐ No ☐
Are you allergic to: Penicillin ☐ Codeine ☐ Local injected anesthetics ☐ Other medications ☐_____
Are you subject to prolonged bleeding? ..... Yes ☐ No ☐
Are you subject to fainting spells? ..... Yes ☐ No ☐
Do you have excessive urination and/or thirst? ..... Yes ☐ No ☐
(women)
Are you pregnant? ..... Yes ☐ No ☐ How long? _____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment. _____

_____

_____
(Patient signature)