LOMBARDO & BASTIANI, DMDs | 332 Federal Road, Brookfield, CT 06804 | (203) 775 – 6202

PATIENT INFORMATION

Patient Name: _____ _____ ____ Date _____
Last First M.I.

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child

Social Security Number: _____ Birthdate: _____

Phone: Home _____ Work _____ Cell _____ Best time to call: ☐ AM ☐ PM

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Mon ☐ Tues ☐ Thurs ☐ Fri

Address: _____ City: _____ State: ____ Zip: _____

HEALTH INFORMATION

Date of last dental visit: _____ Reason for this visit: _____

☐ HIV/AIDS	☐ Epilepsy	☐ High blood pressure	☐ Rheumatic fever
☐ Anemia	☐ Excessive bleeding	☐ Kidney disease	☐ Rheumatism
☐ Arthritis	☐ Fainting	☐ Liver disease	☐ Sinus problems
☐ Artificial joints	☐ Glaucoma	☐ Mental disorder	☐ Stomach problems
☐ Asthma	☐ Hay fever	☐ Nervous disorder	☐ Stroke
☐ Blood disease	☐ Head injuries	☐ Pacemaker	☐ Tuberculosis
☐ Cancer	☐ Heart disease	☐ Pregnancy (due _____)	☐ Ulcers
☐ Diabetes	☐ Heart murmur	☐ Radiation treatment	☐ Venereal disease
☐ Dizziness	☐ Hepatitis	☐ Respiratory problems	☐ Other _____

Please list all allergies: _____

Please list all current medications: _____

Have you ever had any complications following a dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Have you been admitted to the hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____
Name of physician: _____

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 net appointment without fail.

_____ Date _____
Signature of patient, parent, or guardian

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? Name: _____
☐ Another patient/friend ☐ Another patient/relative ☐ Dental office ☐ Insurance company ☐ Other

SPOUSE or RESPONSIBLE PARTY INFORMATION

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

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

Social Security Number: _____ Birthdate: _____

Phone: Home _____ Work _____ Cell _____ Best time to call: ☐ AM ☐ PM

Address: _____ City: _____ State: ____ Zip: _____

EMPLOYMENT INFORMATION

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____ City: _____ State: ____ Zip: _____

INSURANCE INFORMATION

PRIMARY

Name of Insured: _____ _____ ____ Is insured a patient? ☐ Yes ☐ No
Last First M.I.

Insured's Birthdate: _____ ID#: _____ Group #: _____

Insured's Address: _____ _____ ____ _____
Street City State Zip

Insured's Employer Name: _____

Insured's Employer Address: _____ City: _____ State: ___ Zip: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Address: _____ City: _____ State: ___ Zip: _____

Plan Name: _____ Insurance Plan Phone Number: _____

SECONDARY

Name of Insured: _____ _____ ____ Is insured a patient? ☐ Yes ☐ No
Last First M.I.

Insured's Birthdate: _____ ID#: _____ Group #: _____

Insured's Address: _____ _____ ____ _____
Street City State Zip

Insured's Employer Name: _____

Insured's Employer Address: _____ City: _____ State: ___ Zip: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Address: _____ City: _____ State: ___ Zip: _____

Plan Name: _____ Insurance Plan Phone Number: _____