Patient Information and Health History • Steven C. Landin, D.M.D., F.A.G.D.

Fairfield: 203-372-9848 • Newtown: 203-426-6568

INITIAL EXAM | DATE ____________________

Patient's Name ______________________________ | Date of Birth ______________

Patient's Address ______________________________ | ❑ Single ❑ Married ❑ Divorced

Person Responsible for Account ____________________ | ❑ Separated ❑ Widowed

Residence Address ______________________________ | Residence phone ____________

Employed By ______________________________ | Business phone ____________

Business Address ______________________________ | Cell phone ______________

Dental Insurance Plan (If any) ____________________ | Patient's SS# ______________

Referred by ______________________________ | E-mail ______________

Dental History

Chief Oral Complaint ____

Date of last dental exam ______________________ Any previous major dental treatment? ❑ Y ❑ N

Do you have, or do you use any of the following? (please check yes or no)

Yes	No		Yes	No		Yes	No	
❑	❑	Sensitivity to cold, heat, sweets, or pressure	❑	❑	Pain around ear	❑	❑	Mouth breathing
			❑	❑	Unusual sounds in ear while eating	❑	❑	Oral habits, i.e. fingernail biting
❑	❑	Bleeding gums, how long _____	❑	❑	Bad breath or unpleasant taste	❑	❑	Cigarettes, pipe or cigar smoker
❑	❑	Food impaction	❑	❑	Unfavorable dental experience	❑	❑	Dental Floss
❑	❑	Clenching or grinding	❑	❑	Burning of tongue	❑	❑	Inter dental stimulators or waterjet
❑	❑	Swelling or lumps in mouth	❑	❑	Complications from extractions	❑	❑	Fluoride supplements
❑	❑	Frequent blisters on lips or mouth	❑	❑	Periodontal treatment	❑	❑	Orthodontic treatment

Toothbrush texture ______________ Brushing frequency ______________________________

Medical History

Primary physician's name ______________________ Date of last physical exam ______________

Do you have, or have you had any of the following? (please check yes or no)

Yes	No		Yes	No		Yes	No	
❑	❑	Allergies to drugs	❑	❑	Asthma	❑	❑	Stroke
❑	❑	Allergies to anesthetics	❑	❑	Hay fever or allergies in general	❑	❑	Thyroid
❑	❑	Any heart ailments	❑	❑	Diabetes	❑	❑	Eye disorders
❑	❑	High blood pressure	❑	❑	Kidney problems	❑	❑	Tonsillitis
❑	❑	Neurological problems	❑	❑	Liver problems or hepatitis	❑	❑	Tuberculosis
❑	❑	Radiation treatments	❑	❑	Malignancies	❑	❑	Ulcer or colitis
❑	❑	Excessive bleeding from cut or extraction	❑	❑	Psychiatric care/emotional problems	❑	❑	Pregnancy, if so, what month ____
❑	❑	Anemia or blood problems	❑	❑	Rheumatic fever	❑	❑	Venereal disease
❑	❑	Arthritis	❑	❑	Sinus problems	❑	❑	HIV positive
❑	❑	Marked weight change	❑	❑	Pacemaker	❑	❑	AIDS

Describe any current medical treatment including drugs taken, even though not listed above ______________________

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember that this time has been reserved for you.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all of our fees. Each fee is individual for the individual patient.

FINANCE CHARGE: We reserve the right to assess a 1% per month (12% per year) service charge on all accounts past due 60 days or more, unless prior arrangements have been made.

SIGNATURE ______________________________________ DATE ________________