Douglas S.M. Callis D.M.D.
515 Old Toll Road
Madison, CT 06443

(203)421-4100

Patient Name: Last | First | MI | Preferred Name

Chart #. FOR OFFICE USE ONLY

Patient Name: Last | First | MI | Preferred Name

Title: Mr/Ms/Mrs/etc Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: SS #. Prev. Visit:

Email Address: Best time to call:

Phone: Home | Work | Ext | Mobile | Fax | Other

Address:

City | State | Zip Code

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

Within the past year, have there been any changes in your general health? Please explain below.

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

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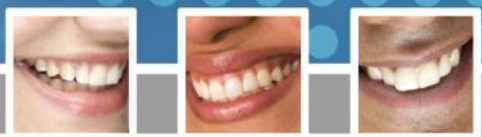

Please indicate if you have experienced any of the following:

- [ ] AIDS
- [ ] Allergy-Codeine
- [ ] Allergy-Erythro
- [ ] Allergy-Hay Fever
- [ ] Allergy-Latex
- [ ] Allergy-Metals
- [ ] Allergy-Narcs
- [ ] Allergy-Other
- [ ] Allergy-Penicillin
- [ ] Allergy-Sulfa
- [ ] Anemia
- [ ] Anxiety
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Artificial Valve
- [ ] Asthma
- [ ] Autoimmune
- [ ] Bleeding Disorder
- [ ] Cancer
- [ ] Contact Lenses
- [ ] Dentalphobic
- [ ] Diabetes
- [ ] DO NOT RECLINE
- [ ] Epilepsy
- [ ] Gag Reflex
- [ ] Glaucoma
- [ ] Hearing Impaired
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart MVP
- [ ] Hepatitis
- [ ] Herpes
- [ ] Hypertension
- [ ] Hypotension
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] MEDS-Anticoag
- [ ] MEDS-Birth Control
- [ ] MEDS-Dilantin
- [ ] MEDS-MAO Inhibitor
- [ ] MEDS-Other
- [ ] NO ANES
- [ ] NO EPI
- [ ] Organ Transplant
- [ ] Other
- [ ] Pacemaker
- [ ] Pregnant
- [ ] PREMED-Amox
- [ ] PREMED-Clindamycin
- [ ] PREMED-Keflex
- [ ] PREMED-Other
- [ ] Psychiatric Care
- [ ] Radiation Tx
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Sinus Problems
- [ ] STDs
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Sycope
- [ ] TB
- [ ] Tumors
- [ ] Ulcers
- [ ] Wheelchair

PLease List the Medications you are currently taking.

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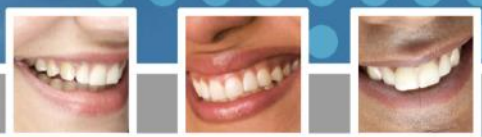

Thyroid Condition

◯ Yes ◯ No

Concussion/Head Injury

◯ Yes ◯ No

Acid Reflux/Gerd

◯ Yes ◯ No

Is there anything about your mouth, teeth, or smile, you would like to change?

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Do you use tobacco (smoking or chewing)?

If any of the previous questions are marked, please explain:

Do you have any other conditions,diseases, health issues or allergies that we should be made aware of?

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date?

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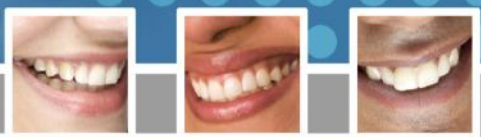

When was your last visit to the dentist (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

Hygenist Comments:

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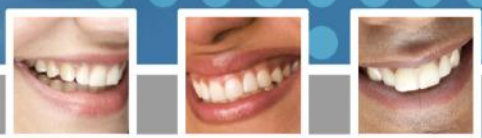

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Do you have dental insurance?

◯ Yes ◯ No

Is the Insurance information we have on record correct?

◯ Yes ◯ No

If the answer is No, please provide a copy of your most recent insurance card and enter insurance information below.

Policy Holders Name:
Social Security #: Date of Birth: Employer:
Carrier: ID# : Group #:

Response Date: _____