

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

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:

Douglas S.M. Callis D.M.D.

515 Old Toll Road
Madison, CT 06443

(203)421-4100



Please indicate if you have experienced any of the following:

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

Please List the Medications you are currently taking.

Douglas S.M. Callis D.M.D.

515 Old Toll Road
Madison, CT 06443

(203)421-4100



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?

Douglas S.M. Callis D.M.D.

515 Old Toll Road
Madison, CT 06443

(203)421-4100



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:

Douglas S.M. Callis D.M.D.

515 Old Toll Road
Madison, CT 06443

(203)421-4100



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 #:

Carrier:

Date of Birth:

ID# :

Employer:

Group #:

Response Date: