Advanced Dentistry of New Canaan

Spencer Meyers, D.D.S
Mark S. DeWaele, D.M.D

PATIENT REGISTRATION AND MEDICAL HISTORY Date:_____

Patient Name :_____ Date of Birth:_____

Last First Middle Initial Age: _____

Sex: Male ❑ Female ❑ Marital Status: Single ❑ Married ❑ Widowed ❑ Divorced❑

Occupation: _____ Employed by _____

Spouse / Parent Name: _____

Street Address:_____ City:_____ State:_____

Zip code:_____ Home Phone:_____ Cell Phone:_____

Email Address:_____

Who will be responsible for your account:
Self ❑ Spouse ❑ Father ❑ Mother ❑ Other ❑ *(If self, skip to next section)*
Name:_____ Phone Number:_____ Address:_____
City:_____ State:_____ Zip code:_____

Emergency Contact:

Name:_____ Phone Number _____ Relationship_____

Primary Physician's Name:_____ Date of Last Physical:_____

Have you ever had any of the following? *(Check boxes that apply):*

❑ Artificial Joints ❑ Heart Problems ❑ Circulatory Problems ❑ Arthritis ❑ Artificial Heart Valve ❑ Epilepsy ❑ Chemical Dependency ❑ Ulcer ❑ A-fib ❑ Stroke ❑ Low Blood Pressure ❑ Sinus Issues ❑ High Blood Pressure ❑ Cancer ❑ Swollen Neck Glands ❑ Headaches ❑ Kidney Disease ❑ General Allergies ❑ Heart Murmur ❑ Psychiatric care ❑ Pacemaker ❑ Respiratory disease ❑ Hepatitis/Liver Disease ❑ HIV/AIDS ❑ Diabetes ❑ Blood Disease ❑ Immunosuppressive Disorder ❑ Hemophilia ❑ Asthma ❑ Radiation Treatment ❑ Chemical Dependency ❑ Back Problems ❑ Rheumatic Fever ❑ Mitral Valve Prolapse ❑ Nervous Problems ❑ STD

Are you now or have you ever taken:

❑ Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba)
❑ Any bone density medications/Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)

Do you have any drug allergies or have you ever had an adverse reaction to any medication? YES NO
*If yes, what medications?*_____

Please list medications you are taking:_____

_____

Women: Do you suspect or are you pregnant: YES NO

Are you nursing? YES NO

Is there anything else we should know about your medical or dental history? YES NO
*If yes, please explain:*_____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance claims. I will not hold my Doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's Signature:_____ **Date:**_____

I authorize the Doctor and his designated staff, to perform an examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination.

Patient's Signature:_____ **Date:**_____

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Patient's Signature:_____ **Date:**_____