# DAVID B. BERNARD, D.D.S.

LEXINGTON MEDICAL CENTER
33 Lexington Street ~ New Britain, CT 06052
Phone: (860) 229-3084
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Date:_______________________

Patient Name:___________________________________________Social Security #: ____________________

Preferred Name:_______________Gender: M F Date of Birth:___/___/___ Age:___ Marital Status:___________

Address:_________________________________________________ Home Phone: ( ) ______________
Street Apt/Bldg

City:______________________ State:_____Zip:_______ Email Address: _________________________

Employer Name / Address: ______________________________________________________________

Occupation:__________________ Business Phone: ( )______________ Cell Phone: ( )______________

Spouse's Name:______________________________DOB: ___/___/___ Soc. Sec. # ____________________

Spouse's Employer Name / Address: _______________________________________________________

Spouse's Occupation:______________________________Business Phone: ( ) ____________ Ext. _______

Whom may we contact in case of emergency? _____________________________________________
Name Relationship Phone

**IF PATIENT IS A MINOR OR STUDENT:**

Responsible Party:_________________________________________Home Phone: ( ) ______________
Name Relationship

Address:______________________________________________ Business Phone: ( ) ______________

**IF PATIENT IS A STUDENT:**

Name of School / College:_____________________________ City:______________________ State: _____

**INSURANCE INFORMATION:**

Primary Insurance:______________________________ Secondary Insurance: ____________________________

Subscriber's Name:______________________________ Subscriber's Name: ____________________________
(The person employed by the company) (The person employed by the company)

Social Security #:______________DOB:___/___/___ Social Security #:______________ DOB:___/___/___

Address: ______________________________________ Address:_______________________________________
(if different than patient) (if different than patient)

ID#:__________________________________________ ID#: __________________________________________

Employer:______________________________________ Employer: ______________________________________

**SIGNATURE ON FILE**

AUTHORIZATION TO PAY BENEFITS:
I hereby authorize payment directly to the above named dentist(s) from my current insurance carrier.

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize the above named dentist(s) to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care, advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administering claims for benefits.

I understand I am responsible for my bill, including any unpaid portion after insurance payment.

Patient's Signature ______________________________________ Date:______________________

Whom may we thank for referring you. ______________________________________________

FORM [illegible]

**MEDICAL HISTORY:**

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. The name and address of my physician is ______________________________
2. My last physical examination was on ______________________________
3. Are you now under the care of a physician? .......... YES NO
   If so, what is the condition being treated? ______________________________
4. Do you have any health problems? .......... YES NO
   If so, please explain ______________________________
5. Has there been any change in your general health within the past year? .......... YES NO
6. Have you had any serious illness or operation? .......... YES NO
   If so, what was the illness or operation? ______________________________
7. Have you been hospitalized or had a serious illness within the past five(5) years? .......... YES NO
   If so, what was the problem? ______________________________
8. Do you have or have you had any of the following diseases or problems?
   a. Heart murmur .......... YES NO
   b. Rheumatic fever or rheumatic heart disease .......... YES NO
   c. Congenital heart lesions .......... YES NO
   d. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) .......... YES NO
      1) Do you have pain in chest upon exertion? .......... YES NO
      2) Are you ever short of breath after mild exercise? .......... YES NO
      3) Do your ankles swell? .......... YES NO
      4) Do you get short of breath when you lie down, or do you require pillows when you sleep? .......... YES NO
      5) Do you have a cardiac pacemaker? .......... YES NO
   e. Allergy .......... YES NO
   f. Sinus trouble .......... YES NO
   g. Asthma or hay fever .......... YES NO
   h. Hives or a skin rash .......... YES NO
   i. Fainting spells or seizures .......... YES NO
   j. Diabetes .......... YES NO
      1) Do you have to urinate (pass water) more than six times a day? .......... YES NO
      2) Are you thirsty much of the time? .......... YES NO
      3) Does your mouth frequently become dry? .......... YES NO
   k. Hepatitis, yellow jaundice or liver disease .......... YES NO
   l. Arthritis .......... YES NO
   m. Inflammatory rheumatism (painful swollen joints) .......... YES NO
   n. Stomach ulcers .......... YES NO
   o. Kidney trouble .......... YES NO
   p. Tuberculosis .......... YES NO
   q. Do you have a persistent cough or cough up blood? .......... YES NO
   r. Low blood pressure .......... YES NO
   s. Venereal disease .......... YES NO
   t. Herpes .......... YES NO
   u. AIDS .......... YES NO
   v. Other ______________________________

*Keep Going – You're Doing Well!*

9. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? YES NO
   a. Do you bruise easily? YES NO
   b. Have you ever required a blood transfusion? YES NO
   If so, please explain the circumstances ______________________________

   ______________________________

10. Do you have any blood disorder such as anemia? YES NO
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your head or neck? YES NO
12. Are you taking any drug or medicine? YES NO
    If so, what? ______________________________
13. Are you taking any of the following:
    a. Antibiotics or sulfa drugs YES NO
    b. Anticoagulants (blood thinners) YES NO
    c. Medicine for high blood pressure YES NO
    d. Cortisone(steroids) YES NO
    e. Tranquilizers YES NO
    f. Antihistamines YES NO
    g. Aspirin YES NO
    h. Insulin, tolbutamide (orinase) or similar drug YES NO
    i. Digitalis or drugs for heart trouble YES NO
    j. Nitroglycerin YES NO
    k. Oral contraceptive or other hormonal therapy YES NO
    l. Other ______________________________
14. Are you allergic or have you reacted adversely to
    a. Local anesthetics (such as Novocaine (Xylocaine)) YES NO
    b. Penicillin or other antibiotics YES NO
    c. Barbiturates, sedatives, or sleeping pills YES NO
    d. Aspirin YES NO
    e. Iodine YES NO
    f. Codeine or other narcotics YES NO
    g. Latex YES NO
    h. Other ______________________________
15. Have you ever had any surgery on a knee, hip, or other joint that required a pin or replacement of that joint? YES NO
    If so, please explain ______________________________

    ______________________________
16. Do you have any disease, condition, or problem not listed above that you think I should know about? YES NO
    If so, please explain ______________________________

    ______________________________
17. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? YES NO

**WOMEN**

18. Are you pregnant? YES NO
19. Are you nursing? YES NO

*One More Side – Please*

**DENTAL HEALTH:**

What prompted you to seek dental care at this time? ______

How would you describe the condition of your teeth and gums?

Excellent ☐ Good ☐ Fair ☐ Poor ☐

Name and address of previous dentist ______

______

How long has it been since your last thorough dental exam? ______

| | | |
|---|---|---|
| Were X-Rays taken of all your teeth at that time? | YES | NO |
| Do you have all your teeth? | YES | NO |
| If not, did you have missing teeth replaced? (Other than wisdom teeth) | YES | NO |
| Were you told why your missing teeth should be replaced? | YES | NO |
| Do you enjoy chewing on both sides of your mouth? | YES | NO |
| Are you happy with the appearance of your teeth? | YES | NO |
| Do you have regular periodic dental check-ups? | YES | NO |
| Would you be disturbed if you had to lose all your teeth? | YES | NO |
| Are you interested in complete dental care? | YES | NO |
| Do you usually have many cavities? | YES | NO |
| Do you lose or break silver fillings? | YES | NO |
| Have you had any serious trouble associated with any previous dental treatment? | YES | NO |

If so, please explain ______

| | | |
|---|---|---|
| Are you familiar with one visit dentistry? | YES | NO |
| Have you ever been shown how to brush and floss your teeth? | YES | NO |
| Would you like to be notified by this office for future preventive check-ups to maintain your dental health? | YES | NO |

How often do you clean your teeth? ______ With What? ______

**Do You Have or Have You Had Any of the Following? (Please Check.)**

| | | | |
|---|---|---|---|
| Bleeding Gums | ☐ | Problems Chewing Hard Foods | ☐ |
| Sensitive Teeth | ☐ | Frequent Blisters (Cold Sores) | ☐ |
| Food Wedging Between Teeth | ☐ | Burning Tongue | ☐ |
| Periodontal (Gum)Treatment | ☐ | Swelling or Lumps in Mouth | ☐ |
| Clenching or Grinding Your Teeth | ☐ | Sinus Trouble | ☐ |
| Pain in the Region of the Ear | ☐ | Gagging Difficulties | ☐ |
| Unusual Sound in Ear While Eating (Clicking) | ☐ | Root Canal (Endodontic Treatment) | ☐ |
| | | Orthodontic Treatment | ☐ |

Do you eat sweets? ______

Do you have a complete breakfast every day? ______

Are you interested in learning about nutrition? ______

Do you smoke? ☐ Yes ☐No If yes, please specify.

______ number of cigarettes per day; ______ pipefuls; ______ cigars

When you have your dentistry performed do you have...

| Xylocaine (Novocaine)? | | Nitrous Oxide (Laughing Gas, Sweet Air)? | |
|---|---|---|---|
| Sometimes | ☐ | Sometimes | ☐ |
| Always | ☐ | Always | ☐ |
| Never | ☐ | Never | ☐ |

Are you nervous or frightened during dental visits? If yes, please circle

Least Nervous 0 1 2 3 4 5 6 7 8 9 10 Most Nervous

*TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT IF I EVER HAVE A CHANGE IN MY HEALTH; OR, IF MY MEDICINES CHANGE, I WILL INFORM THE DOCTOR AT THE NEXT APPOINTMENT WITHOUT FAIL.

______ Date ______ Sigature of Patient

______ Date ______ Sigature of Dentist