Welcome

NAGESH D. SHRESTHA DDS, LLC
300 Bank Street
Seymour, CT 06483

Patient Information

DOB _____

Name _____ *Soc Security #* _____
Last Name First Name Middle Initial

Address _____ *City* _____ *State* _____ *Zip* _____

Home Phone _____ *Cell Phone* _____

Occupation _____ *Business/Employer* _____

Bus/Employer Address _____

Bus/Employer Phone _____ *e-mail* _____

Referred By _____

In case of emergency who should be notified? _____ *Phone* _____

Insurance

Primary Insurance	Secondary Insurance
Insurance Co _____	*Insurance Co* _____
Subscriber name _____	*Subscriber name* _____
ID#/SS# _____	*ID#/SS#* _____
DOB of Subscriber _____	*DOB of Subscriber* _____
Employer of Insured _____	*Employer of Insured* _____
City/State/Zip _____	*City/State/Zip* _____

Dental History

Former dentist _____ *Date of last dental care* _____

Reason for visit _____ *Interested in Teeth whitening* *Yes No Maybe*

Check(√) if you have had problems with any of the following:

□ *Bad breath*	□ *Grinding/Clenching teeth*	□ *Sensitivity to hot*
□ *Bleeding gums*	□ *Loose or Broken fillings*	□ *Sensitivity to sweets*
□ *Clicking or Popping of jaw*	□ *Periodontal treatment*	□ *Sensitivity when biting*
□ *Food collection between teeth*	□ *Sensitivity of cold*	□ *Unhealed area in mouth*

How often do you floss _____ *How often do you brush* _____

Medical History

*Physician's Name*_____ *Phone*_____

Are you in good health? □ *Yes* □ *No*

Have you had any serious illness or operation? □ *Yes* □ *No* *If yes, describe*_____

_____

Check (√) if you have or have had any of the following:

□ *Anemia*
□ *Arthritis, Rheumatism*
□ *Artificial Heart Valve*
□ *Artificial Joints*
□ *Asthma*
□ *Anxiety*
□ *AIDS/HIV*
□ *Cancer*
□ *Chemical dependency*
□ *Chemotherapy*
□ *Cholestrol*
□ *Diabetes*
□ *Depression*
□ *Epilepsy*
□ *Emphysema*
□ *Fainting*
□ *Glaucoma*
□ *Gastric Reflux*
□ *Headaches*
□ *Heart Murmur*
□ *Heart Problems*
□ *Hemophilia*
□ *Hepatitis*
□ *High Blood Pressure*
□ *Kidney Disease*
□ *Lupus*
□ *MVP*
□ *Osteoporosis*
□ *Psychiatric care*
□ *Pacemaker*
□ *Prostate*
□ *Rheumatic Fever*
□ *Radiation Rx*
□ *Shortness of Breath*
□ *Stroke*
□ *Tobacco Habit* _____
□ *Thyroid Problem*
□ *Tuberculosis*
□ *Ulcer*
□ *Other*

(women) Are you pregnant? □ *Yes* □ *No* *Nursing?* □ *Yes* □ *No*

Medications

_____
_____
_____
_____

Allergies

_____
_____
_____

*Sign:*_____ *Date:*_____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with_____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature to all insurance submissions.

The above named dentist may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payments for services and determining insurance benefits or benefits payable to related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Sign

_____
Print name

_____
Date

_____
Relationship to patient