Middlebury
DENTAL GROUP

CONTACT UPDATE

Print Name: _____ Date:_____

Address: _____

Email _____

Home _____

Cell _____

Work _____

Please check which would be your preferred method of confirmation.

☐ email ☐ Home ☐ Call to Cell ☐ Text message ☐ Call to work #

Your current dental insurance is:_____

You are: ☐ Policy Holder ☐ Dependent

Peter J. Hopper, DDS * Adam E. Fasoli, DMD
1330 EXCHANGE ST, SUITE 107 * MIDDLEBURY, VT 05753 * (802) 388-3553

Middlebury
DENTAL GROUP

_____
Patient Name (Please Print)

I acknowledge that I have been presented with a copy of Middlebury Dental Group's Notice of Privacy Practices.

_____ _____
Patient Signature Date

OR

_____ _____
Signature of Parent or Guardian Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign _____
Communication barriers prohibited obtaining the acknowledgement _____
An emergency situation prevented us fro obtaining acknowledgement ___
Other_____Please Specify_____

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Medical History 2017(Copy)

Patient Name: Birth Date: Date Created:

Please check any of the following that apply to you

☐ Sensitivity (hot, cold, sweet)	☐ Tooth Pain or discomfort when chewing	☐ Headaches, earaches, neck pain
☐ Jaw joint pain	☐ Teeth or Fillings breaking	☐ Grinding or clenching teeth
☐ Bleeding, swollen or irriatated gums	☐ Loose, Chipped or shifting teeth	☐ Bad breath or bad taste in your mouth

Please check the most important thing to you about your dental visit today

☐ Preventitive Hygiene ☐ Future Treatment Plan ☐ Cosmetic

Other: ☐ If yes

If you could whiten your teeth for a cost anyone could afford, would you do it? ◯ Yes ◯ No

Do you smoke or use chewing tobacco? ◯ Yes ◯ No

How much?

How long?

Health rating

On a scale of 1-10, with 10 being the highest:

Where would you rate your current dental health?

How important is your dental health to you?

If I could change my smile, I would:

Make my teeth whiter ◯ Yes ◯ No	Make my teeth straighter ◯ Yes ◯ No	Close spaces ◯ Yes ◯ No
Replace metal fillings with tooth co ◯ Yes ◯ No	Repair chipped teeth ◯ Yes ◯ No	Replace old crowns that don't m ◯ Yes ◯ No
Have a smile makeover ◯ Yes ◯ No		

If you are new to our office

Please share the following dates:

Your last cleaning

Your last oral cancer screening

Your last x-rays

Please check any of the following that apply to you:

☐ AIDS	☐ Allergies	☐ Anemia	☐ Arthritis
☐ Artificial Heart Valve	☐ Artificial Joint	☐ Asthma	☐ Blood Disease
☐ Bruise Easily	☐ Cancer	☐ Chemotherapy	☐ Diabetes
☐ Dizziness	☐ Drug Addiction	☐ Emphysema	☐ Excessive Bleeding
☐ Fainting	☐ Glaucoma	☐ Heart Condition	☐ Heart Lesions
☐ Heart Murmur	☐ Heart Surgery	☐ Hepatitis B	☐ Hepatitis B
☐ Hepatitis C	☐ High Blood Pressure	☐ HIV	☐ Jaundice
☐ Jaw Joint Pain	☐ Kidney Disease	☐ Liver Disease	☐ Low Blood pressure
☐ Mitral Valve Prolapse	☐ Nervousness/Depression	☐ Pacemaker	☐ Phen Fen
☐ Pregnant Currently	☐ Radiation (head/neck)	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Rheumatism	☐ Scarlet Fever	☐ Seizures	☐ Stomach Problems
☐ Stroke	☐ Thyroid Disease	☐ Tuberculosis	☐ Ulcers
☐ Veneral Disease			

Other: ☐ If yes

Allergies

Do you have any of the following drug allergies?

Aspirin ◯ Yes ◯ No	Codeine ◯ Yes ◯ No	Darvon ◯ Yes ◯ No
Erythromycin ◯ Yes ◯ No	Nirtous Oxcide ◯ Yes ◯ No	Valium ◯ Yes ◯ No
Percodan ◯ Yes ◯ No	Penicillin ◯ Yes ◯ No	Local Anesthetic ◯ Yes ◯ No

Other: ◯ Yes ◯ No If yes

Are you under a physician's care? ◯ Yes ◯ No If yes

Primary ◯ Yes ◯ No

Specialist ◯ Yes ◯ No

Are you taking any medications? Please list ◯ Yes ◯ No If yes

Is there any other medical or dental information we should know about? ◯ Yes ◯ No If yes

Signature of Patient, Parent or Guardian:

X Date:_____

Welcome To Middlebury Dental Group

We are pleased to welcome you to our office. Please take a few minutes to fill out this form.
If you have any questions, we'll be glad to help.

PATIENT INFORMATION

Patient Name _____
First Last MI (Preferred)

Address _____ Address 2 _____

City _____ State _____ Zip _____

Hm Phone _____ Cell_____ Work_____

Preferred contact method for confirmations: [ ] HmPhone [ ] WkPhone [ ] Mobile Phone [ ] Text [ ] E-mail

E-mail address _____

Date of Birth:_____ Sex: [ ] Female [ ] Male Social Sec #_____

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

New Patient? [ ] Y [ ] N *If yes, how did you hear of our office?* _____

RESPONSIBLE PARTY- ***required if patient is a child, or if policy holder of insurance is someone other than patient.***

Name of Responsible _____
First Last MI (Preferred)

Check box if address is same for entire family [ ] If address if different, please enter below

Address _____ Address 2 _____

City _____ State _____ Zip _____

Hm Phone _____ Cell_____ Work_____

Preferred contact method for confirmations: [ ] HmPhone [ ] WkPhone [ ] Mobile Phone [ ] Text [ ] E-mail

E-mail address _____

Date of Birth:_____ Sex: [ ] Female [ ] Male Social Sec #_____

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

INSURANCE POLICY 1 (*Primary*)

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child [ ] Other

Subscriber Name _____ Subscriber DOB _____

Employer _____ Subscriber ID # _____

Insrance Company _____ Group # _____

Ins. Co Address _____ Subscriber Social Sec #_____

INSURANCE POLICY 2 (*Secondary*)

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child [ ] Other

Subscriber Name _____ Subscriber DOB _____

Employer _____ Subscriber ID# _____

Insrance Company _____ Group # _____

Ins. Co Address _____ Subscriber Social Sec # _____