MICHAEL S. TOSATTI, DMD

1067 Farmington Avenue • Kensington, CT 06037 • 860-828-1475

Dentistry for Adults and Children

Health History

Name _____ Sex ___ Age ___ Marital Status S ___ M ___ W ___ D ___

Street _____ Birth Date _____ SS# _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail _____ Employed By _____ Referred By _____

Person Responsible for Payment? _____

For the following questions, please (x) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

DENTAL HISTORY

	Yes	No
1. Do you have any immediate dental problems?	❑	❑
Please explain _____		
2. When was your last dental visit? _____		
3. Do you have or have you ever had and discomfort related to the opening and closing of your jaw?	❑	❑
4. Do your gums bleed?	❑	❑
When? _____		
5. Do you feel you have bad breath at times?	❑	❑
6. Are your teeth sensitive to hot, cold or sweets?	❑	❑
7. Are you happy with the appearance of your teeth when you smile?	❑	❑
8. Do you want to keep the natural teeth you have?	❑	❑
9. Do you have a fear of Dentistry?	❑	❑
10. Do you have loose teeth or full or partial dentures?	❑	❑

MEDICAL HISTORY

	Yes	No
Are you in good health?	❑	❑
Are you now under the care of a physician?	❑	❑

If yes, what is/are the conditions(s) being treated?

_____

_____

Physician: _____

NAME PHONE

Have you had any serious illness, operation, or been hospitalized in the past 5 years?	❑	❑

If yes, what was the illness or problem?

_____

_____

_____

Do you use tobacco (smoking, snuff, chew)?	❑	❑

If yes, how interested are you in stopping?

(Circle one) Very / Somewhat / Not interested

	Yes	No
Are you taking or have you taken any medicine(s) including non-prescription medicine?	❑	❑

If yes, what medicine(s) (pills, patches, sprays, inhalers, etc.) are you taking?

Prescribed (medication(s)/dosage):

_____

_____

_____

Over the counter (including aspirin): _____

_____

Other alternative medical therapies: _____

_____

Vitamins, natural or herb preparations and/or diet supplements:

_____

	Yes	No
Have you had and orthopedic total joint (hip, knee, elbow, finger) replacement?	❑	❑

If yes, when was this operation done? _____

If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint?

_____

_____

	Yes	No
Do you wear contact lenses?	❑	❑
Have you ever had an allergic reaction to any drugs, foods, medications or materials?	❑	❑

If yes, specify type of reaction

_____

_____

_____

Please (x) a response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No
Abnormal bleeding	❑	❑
AIDS or HIV infection	❑	❑
Anemia	❑	❑
Arthritis	❑	❑
Asthma	❑	❑
Cancer/Chemotherapy/Radiation Treatment	❑	❑

Cardiovascular disease. If yes, specify below:

___Angina
___Arteriosclerosis
___Artificial heart valves
___Congenital heart defects
___Congestive heart failure
___Coronary artery disease
___Heart attack
___Heart Murmur
___High blood pressure
___Low blood pressure
___Mitral valve prolapse
___Pacemaker
___Rheumatic heart disease/ Rheumatic fever
___Automatic Implantable Cardio defibrillator (ACID, ICD)

Chronic pain	❑	❑
Diabetes	❑	❑
Dry mouth	❑	❑
Eating disorder. If yes, specify: _____	❑	❑
Epilepsy	❑	❑
Faint spells or seizures	❑	❑
G.E. Reflux/persistent heartburn	❑	❑
Glaucoma	❑	❑
Have you taken any drug called Cortisone, Steroid, or ACTH within the past two years?	❑	❑
Have you ever taken any blood thinners in the past week?	❑	❑
Do you bruise easily or bleed excessively?	❑	❑
Have you ever had a bad reaction to a local or general anesthetic?	❑	❑

What kind of problem?

_____

_____

	Yes	No
Hepatitis, jaundice, or liver disease	❑	❑
Recurrent infections	❑	❑
If yes, indicate type of infection: _____		
Kidney problems	❑	❑
Mental health disorders. If yes, specify: _____	❑	❑
Osteoporosis		
Respiratory problems. If yes, specify below: ___Emphysema ___Bronchitis, etc.		
Sexually transmitted disease	❑	❑
Sinus trouble	❑	❑
Sores or ulcers in the mouth	❑	❑
Stroke	❑	❑
Systemic lupus erythematosus	❑	❑
Tuberculosis	❑	❑
Thyroid problems	❑	❑
Ulcers	❑	❑
Do you have any disease, condition or problem not listed above that you think I should know about?	❑	❑

Please explain: _____

_____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑

If yes, what antibiotic and dose? _____

For Women only:

Are you or could you be pregnant?	❑	❑
Nursing?	❑	❑
Taking birth control pills or hormonal replacement?	❑	❑

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

The above information is true to the best of my knowledge. I hereby grant Michael S. Tosatti D.M.D., 1067 Farmington Avenue, Kensington, CT 06037, to administer any treatment agreed upon or to administer such anesthetics and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

_____ _____

Signature of patient/legal guardian Michael S. Tosatti, DMD

HEALTH INFORMATION UPDATE (DO NOT COMPLETE ON FIRST VISIT)

I have reviewed and updated my patient information sheet and recorded any changes.

Patient's Signature _____ Date _____