PO Box 468
Greenwich, CT 06836
Phone: 203-818-1090
Fax: 914-740-7604

Date:

PATIENT INFORMATION

Name: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss

First Name: _____ Last Name: _____

Birth Date: _____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Not Specify

SSN: _____

Driver License: _____

Address: _____ Apt#: _____

City: _____ State: _____ ZIP*: _____

Home: _____

Mobile: _____ Carrier: _____

Email: _____

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INSURANCE INFORMATION

Primary Insurance

Subscriber Name:

First Name: _____

Last name: _____

Subscriber D.O.B: _____

Subscriber ID: _____

Medicaid#: _____

Subscriber Address:

_____

City: _____

State: _____

Zip: _____

Relation to Subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other

Employer: _____

Insurer: _____

Insurer Phone:

Group Plan: _____

Group#: _____

Secondary Insurance

Subscriber Name:

First Name: _____

Last name: _____

Subscriber D.O.B: _____

Subscriber ID: _____

Medicaid#: _____

Subscriber Address:

_____

City: _____

State: _____

Zip: _____

Relation to Subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other

Employer: _____

Insurer: _____

Insurer Phone:

Group Plan: _____

Group#: _____

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Health History

Care Selection and Responsible Party

Exams

I want an initial exam only	☐ Yes	☐ No
I want an initial exam and recall exams every 6 months	☐ Yes	☐ No

Cleanings

I do not want cleanings	☐ Yes	☐ No
I want one cleaning only	☐ Yes	☐ No
I want cleanings every 3 months (Recommended)	☐ Yes	☐ No
I want cleanings every 6 months	☐ Yes	☐ No

Fluoride Treatment

I want to receive fluoride treatments.	☐ Yes	☐ No
I do not want to receive fluoride treatments. I understand that fluoride treatments help prevent tooth decay and are recommended by the American Dental Association	☐ Yes	☐ No

X-rays: X-rays are required for all new patients as per state laws. Recall X-rays are only taken as needed. We follow the American Dental Association guidelines on X-ray periodicity.

PRIMARY RESPONSIBLE PARTY/ MEDICAL POWER OF ATTORNEY (IF APPLICABLE)

First Name

Last Name

Date of Birth

Address

CellPhone

HomePhone

Email

Relation to Patient

FINANCIAL POWER OF ATTORNEY (IF APPLICABLE AND DIFFERENT FROM ABOVE)

First Name

Last Name

Date of Birth

Address

Cell Phone

HomePhone

Email

Relation to Patient

EMERGENCY CONTACT

Name

Relation to Patient

Telephone Number(s)

If you are a party legally responsible for the patient and will not be able to be present during the visit, you have an option of filling out the credit card authorization below. This is also an option for patients who want us to keep their credit card information on file to simplify the payment process for them. Rest assured that we will not charge your card without your approval.

CREDIT CARD AUTHORIZATION (WE WILL SEND YOU A RECEIPT)

Credit Card Number

Expiration Date

Card Security Code

Name on Credit Card (exactly how it appears)

Billing Address

I authorize On The Go Dental Group to charge the above Credit Card for dental services rendered to me. I agree to 3.5% processing fee for Credit Card payments.

Name/Signature

Date

Name of your physician?

Date of last dental/dental hygiene visit?

COVID-19 Screening

1. Have you traveled internationally in the last 14 days? ☐ Yes ☐ No

If yes, please provide your return date.

2. Have you been tested for COVID-19? ☐ Yes ☐ No

If yes, what type of test, date of test and the results of the test.

3. Have you been in close contact with another person who has been diagnosed for COVID-19? ☐ Yes ☐ No

4. Do you have a dry cough, flu-like symptoms, fever, headache, fatigue or shortness of breath? ☐ Yes ☐ No

5. Have you experienced recent loss of taste or smell? ☐ Yes ☐ No

6. Current body temperature °F:

Medical History

1. Are you under medical treatment now? ☐ Yes ☐ No

2. Have you ever been hospitalized for any surgical operation or serious illness? ☐ Yes ☐ No

3. Are you taking any medication(s) including non-prescription medicine? ☐ Yes ☐ No

If yes, what medication(s) are you taking?

4. Do you use tobacco? ☐ Yes ☐ No

5. Do you use alcohol? ☐ Yes ☐ No

6. Do you use cocaine or other drugs? ☐ Yes ☐ No

7. Are you wearing contact lenses? ☐ Yes ☐ No

8. Are you allergic to or have you had any reactions to the following?

Aspirin	☐ Yes ☐ No	Penicillin or other antibiotics	☐ Yes ☐ No
Barbiturates	☐ Yes ☐ No	Sedatives	☐ Yes ☐ No
Iodine	☐ Yes ☐ No	Sulfa drugs	☐ Yes ☐ No
Local anesthetics (e.g. Novocain)	☐ Yes ☐ No	Other	

9. Women only:
   a. Are you pregnant or think you may be pregnant? ☐ Yes ☐ No
   b. Are you nursing? ☐ Yes ☐ No
   c. Are you taking birth control pills? ☐ Yes ☐ No

10. Do you have or have you had any of the following?

AIDS or HIV infection	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Kidney diseases	☐ Yes ☐ No

Asthma	☐ Yes	☐ No	Joint replacement or implant	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Liver disease	☐ Yes	☐ No
Cardiac pacemaker	☐ Yes	☐ No	Low blood pressure	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No	Radiation therapy	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Recent weight loss	☐ Yes	☐ No
Easily winded	☐ Yes	☐ No	Respiratory problems	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No
Epilepsy/Convulsions	☐ Yes	☐ No	Sexually transmitted diseases	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Stomach troubles/Ulcers	☐ Yes	☐ No
Hay fever/Allergies	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No	Swollen ankles	☐ Yes	☐ No
Heart diseases	☐ Yes	☐ No	Thyroid problem	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart trouble	☐ Yes	☐ No	Other		
Hepatitis/Jaundice	☐ Yes	☐ No			

Dental History

1. Do your gums bleed while brushing or flossing?	☐ Yes	☐ No
2. Are your teeth sensitive to hot or cold liquid/food?	☐ Yes	☐ No
3. Are your teeth sensitive to sweet or sour liquid/food?	☐ Yes	☐ No
4. Do you feel pain to any of your teeth?	☐ Yes	☐ No
5. Do you have any sores or lumps in or near your mouth?	☐ Yes	☐ No
6. Have you had any head, neck or jaw injuries?	☐ Yes	☐ No
7. Have you ever experienced any of the following problems in your jaw?		
a. Clicking?	☐ Yes	☐ No
b. Pain (joint, ear, side of face)?	☐ Yes	☐ No
c. Difficulty in opening or closing?	☐ Yes	☐ No
d. Difficulty chewing?	☐ Yes	☐ No
8. Do you have frequent headaches?	☐ Yes	☐ No
9. Do you clench or grind your teeth?	☐ Yes	☐ No
10. Do you bite your lips or cheeks frequently?	☐ Yes	☐ No
11. Have you had any difficult extractions in the past?	☐ Yes	☐ No
12. Have you had any orthodontic work?	☐ Yes	☐ No

13. Have you had any prolonged bleeding following extractions?	☐ Yes	☐ No
14. Have you ever had instruction on the correct method of brushing your teeth?	☐ Yes	☐ No
15. Have you ever had instructions on the care of your gums?	☐ Yes	☐ No

I have read my History and confirm that it adequately reflects past and present conditions.

Authorized signature of covered person (For minor, Parent or Guardian)

Signature	Print Name	Date

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ON THE GO DENTAL GROUP

Date:

SIGNATURE ON FILE

The undersigned here by authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature authorizes my dentist to submit claims for benefits for services rendered or to be rendered without my signature on every claim submitted for my dependants.

Authorized signature of covered person (For minor, Parent or Guardian)

Signature	Print Name	Date

The undersigned authorizes payment directly to **On The Go Dental Group** otherwise payable to him/her

Authorized signature of covered person (For minor, Parent or Guardian)

Signature	Print Name	Date

Our office has a strict policy where a $50 fee will be charged for broken appointments unless 24 hrs advance notice is given so that we may reschedule you or reserve that time for another patient

Authorized signature of covered person (For minor, Parent or Guardian)

Signature	Print Name	Date