Bristol Burlington Senior Dental Program Application

1. Please complete the attached forms.
2. Please answer every question.
3. Return the complete forms to:

Bristol-Burlington Health District
240 Stafford Avenue
Bristol, CT 06010
860-584-7682

After the forms are reviewed, you will be called with your appointment date and time.

Thank you!
Bristol Burlington Senior Dental Program

Name: ____________________________  (last)  (first)  Middle initial)  Client #: __________

Address: ________________________________________________________________

Phone Number: ____________________________

My __ If Married, Total

Total Number in household: ___  Monthly income: ____  Monthly Income: ____

Emergency Contact:

Phone Number of Emergency Contact: ____________________________

Primary Physician: ____________________________

Address: ________________________________________________________________

Phone #: ____________________________

Please answer the following questions by circling the appropriate answer and providing any needed explanations:

Have you regularly (6 months-1 year) seen a dentist?  YES  NO
If yes, who? ____________________________

Do you have dental insurance?  YES  NO

(Please note: If your answer is YES, this program applies only to services not covered in any way by the insurance. The usual deductibles and copayments will apply to the covered service.)

How did you hear about this service? ____________________________

I hereby certify that all of the above information is true and correct. I understand that this information is being given in connection with the receipt of reduced fees for dental services and therefore should be verifiable.

Signature of Participant ____________________________  Date __________

For office use only

Approved _____  Denied _____  Reason for denial ____________________________

Date _________  Approving Official ____________________________  Date _________
HEALTH INFORMATION

Please answer all questions. Circle YES or NO and provide additional information requested.

Are you in good health now? YES NO
If not, please explain

Have you been under the care of a physician within the past two years? YES NO
If yes, please explain

Are you taking any medications or pills? YES NO
If yes, please list (include those bought without a prescription):

Are you allergic to penicillin, anesthetics, other medications? YES NO
If yes, please list

Do you smoke? YES NO
If yes, how much per day?

Have you ever had radiation therapy for tumors or cancer? YES NO

Do you have a history of alcoholism? YES NO

Do you use recreational drugs? YES NO

Have you ever had any of the following diseases or problems?
Please check yes or no.

YES NO YES NO YES NO
____ Allergies ______ Glaucoma ______ Nervous Disorders
____ Anemia ______ Headaches ______ Prolonged Bleeding
____ Asthma ______ Heart Disease ______ Stomach Problem
____ AIDS/HIV ______ Rheumatic Fever ______ Tuberculosis
____ Blood Disease ______ Heart Murmur ______ Tumors/Growths
____ Bone Disease ______ Hepatitis ______ Ulcers
____ Cancer ______ High Blood Pressure ______ Chest Pain
____ Fainting ______ Earaches ______ Epilepsy
____ Jaundice ______ Diabetes ______ Jaw Pain or clicking
____ Emotional Disorders
____ Endocrine Disorders
____ Joint Replacement ______ (e.g. hip or knee)
____ Other problems not mentioned: ____________________________
____ Kidney Disease _________________________________________
____ Lung Disease ___________________________________________
____ Liver Disease ___________________________________________

The above information is true and current to the best of my knowledge, and I, the undersigned, give permission for an oral screening and cleaning.

__________________________________________
Signature of Participant

__________________________________________
Date