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: _____ Client #: _____
(last) (first) Middle initial) Date of Birth:_____
Address: _____
_____
Phone Number: _____

My If Married, Total
Total Number in household: ____ Monthly income: _____ Monthly Income: _____

Emergency Contact: _____
(name) (relationship)
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