

87 Chestnut Street
Needham, MA 02492-2514
781-444-6650



Please complete
and bring to 1st
visit

38 Pond Street, Suite 204
Franklin, MA 02038-3826
508-520-6660

**PATIENT INFORMATION
&
HEALTH HISTORY FORM**

Reviewed by
Dr.
Date

Name _____ D.O.B. _____

Mailing Address: Street _____ Place of Birth _____
City _____ State _____ Zip _____ Tel # _____

Home Email Address: _____ Cell # _____

Billing Address: Street _____
(If different than above) City _____ State _____ Zip _____

Occupation: _____ Name of Employer _____
Street _____ Work Tel # _____
City _____ State _____ Zip _____

Work Email Address: _____

Whom may we contact in case of emergency?

Name _____ Relationship _____ Tel # _____
Street _____ Work Tel # _____
City _____ State _____ Zip _____ E-mail Address: _____

Physician _____

Street _____ Tel # _____
City _____ State _____ Zip _____

Previous Dentist _____

Street _____ Tel # _____
City _____ State _____ Zip _____

Whom may we thank for referring you? _____

Do you have any form of Dental Insurance? Y N (if yes, please complete insurance information form enclosed).

Signature _____

Date _____

(continued on next page)

DENTAL HEALTH HISTORY

Reason(s) for seeking dental care:

- | | | |
|------------------------------------------------|----------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Examination | <input type="checkbox"/> Appearance of teeth | <input type="checkbox"/> 2nd Opinion |
| <input type="checkbox"/> Routine check-up | <input type="checkbox"/> Crowding of teeth | <input type="checkbox"/> Consultation |
| <input type="checkbox"/> Toothache or swelling | <input type="checkbox"/> Accident | <input type="checkbox"/> Orthodontic Eval. |
| <input type="checkbox"/> Other _____ | | |

If you have been to a dentist previously,

When was your last visit? _____

When were your last xrays taken? _____

Have you ever had local anesthetic ("Novacaine")? Y N

Were there any complications or adverse reactions? _____

Are you missing any teeth (including "wisdom" teeth)? Y N

Do you wear a dental prosthesis (crowns, bridges, partial, full denture)? Y N

Do you use dental floss in cleaning your teeth?

If so, how often? _____

What kind of tooth brush do you use? Hard Med Soft Electric

How many times/day do you consume food/beverages with high sugar content? _____

Have your teeth ever been injured?

When? (Age) _____

Which teeth? _____

Cause? _____

Describe any treatment _____

Do you have any of the following habits?

Night grinding (bruxism) Y N

Clenching Y N

Mouth breathing Y N

Do you presently wear or have you ever worn a night guard? Y N

Have you received any unusual dental or surgical treatment to the mouth?

If yes, describe _____

MEDICAL HISTORY

Is a physician currently treating you for a specific illness?

If yes, for what reason? _____ Y N

Are you currently taking any medications, including oral contraceptives or aspirin?

Y N

Drug	Reason

Have you taken any unusual medications, including Phen-Phen and Redux, in the past?

If yes, what and why? _____ Y N

Have you had any allergic reactions to

Y N

Medications or drugs? _____

Foods or dyes? _____

Latex or other? _____

Have you ever been hospitalized?

Y N

If yes, when and where? _____

Reason for hospitalization? _____

Have you had any surgery (operations)?

Y N

Date(s) and Age(s)? _____

For what reason(s)? _____

Was general anesthesia used? _____

Were there any complications? _____

Do you now, or have you ever used tobacco products?

How much? _____ For how long _____

Do you consume alcoholic beverages?

How often? _____

Do you have any history of the following diseases or conditions?

- | | | |
|-----------------------------------------------|-----------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting (often) | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gastrointestinal Disorders | <input type="checkbox"/> Nutritional Deficiency |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Loss: Type _____ | <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Heart Disease/Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bleeding (prolonged) | <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Transfusion of Blood |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Herpes | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Cancer: Type _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sickle Cell Trait or Disease |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> HIV Infection (AIDS) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Syndrome: Type _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Emotional disability | <input type="checkbox"/> Leukemia: Type _____ | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Lyme Disease | |

Are you pregnant?

Y N

MEDICAL HISTORY UPDATES

(to be completed at subsequent visits)

Date

Please review the original patient information. If there are any changes in the history, please comment below. If there are no changes, please so state.

Signature _____ Reviewer _____

Date

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