

BOSTON DENTAL DESIGN

PATIENT INFORMATION

Date: _____
First name: _____ Last name: _____
Preferred name: _____
Gender: F M Marital status: _____
Birth date: _____
Social Security #: _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____
Home phone: _____
Work phone: _____
Cell phone: _____
Whom may we thank for referring you to our office?
 Google Yelp ZOOM Facebook
 Other: _____ Friend: _____
Notify in case of emergency: _____ Phone: _____

EMPLOYMENT

Patient's employer: _____
Occupation: _____
Employer address: _____
City: _____ State: _____ Zip: _____

INSURANCE

Insurance company: _____
Subscriber's name: _____
Relationship to patient: _____
Subscriber's birth date: _____
Subscriber's ID#: _____
Subscriber's group name: _____
Insurance group #: _____

DENTAL HISTORY

Reason for today's visit: _____
Former dentist: _____
Phone: _____
Why did you leave your last dentist? _____
Date of last dental visit: _____
Date of last x-rays: _____
How often do you brush? _____
How often do you floss? _____

(x) if you have or have had any of the following:

- | | |
|--|---|
| <input type="checkbox"/> abscess in mouth | <input type="checkbox"/> loose teeth or broken fillings |
| <input type="checkbox"/> bleeding gums | <input type="checkbox"/> missing teeth |
| <input type="checkbox"/> clenching/grinding teeth | <input type="checkbox"/> mouth odors or bad tastes |
| <input type="checkbox"/> clicking/popping/pain in jaw | <input type="checkbox"/> nail biting |
| <input type="checkbox"/> cold sores/oral lesions/growths | <input type="checkbox"/> oral surgery : _____ |
| <input type="checkbox"/> dental anxiety | <input type="checkbox"/> orthodontic treatment: _____ |
| <input type="checkbox"/> dental appliances: _____ | <input type="checkbox"/> periodontal treatment: _____ |
| <input type="checkbox"/> dry mouth | <input type="checkbox"/> root canal |
| <input type="checkbox"/> extractions | <input type="checkbox"/> sensitive gums |
| <input type="checkbox"/> food collection between teeth | <input type="checkbox"/> sensitivity to hot/cold/sweet |
| <input type="checkbox"/> gag easily | <input type="checkbox"/> other: _____ |

Are you satisfied with the appearance of your teeth? Yes No

If you answered no, please explain what you would like to change:

Would you like a whiter smile? Yes No

MEDICAL HISTORY

Are you currently under physician care? _____

If so, please explain: _____

Physician's name: _____

Phone: _____

Have you had any operations or serious illnesses? Yes No

If so, please explain: _____

Women: are you pregnant? _____

If so, how many months? _____ Nursing? _____

Taking birth control pills? _____

(x) if you have or have had any of the following:

- | | | |
|---------------------------------|---------------------------------|---|
| <input type="checkbox"/> anemia | <input type="checkbox"/> angina | <input type="checkbox"/> arthritis/rheumatism |
|---------------------------------|---------------------------------|---|

- artificial heart valves
- artificial joints
- asthma
- back problems
- blood disease
- blood transfusion
- cancer/tumors
- chemical dependency
- chemotherapy
- circulatory problems
- congenital heart lesions
- cortisone treatments
- cough ,persistent
- cough up blood
- diabetes
- Emphysema
- epilepsy/seizures

- fainting/ dizziness
- glaucoma
- headaches
- heart murmur
- heart problems
- hemophilia/ abnormal bleeding
- hepatitis: type____
- herpes
- high blood pressure
- HIV+/AIDS
- jaundice
- jaw pain
- kidney disease
- knee/joint replacement
- liver disease
- mitral valve prolapse
- pacemaker/heart surgery
- psychiatric care

- radiation treatment
- rapid weight gain or loss
- respiratory disease
- rheumatic/scarlet fever
- shortness of breath
- sinus problems
- skin rash
- stroke
- swelling of feet/ankles
- thyroid disease
- tobacco habit

How many cigarettes/day?

-
- tonsillitis
 - tuberculosis
 - ulcer
 - venereal disease

Do you have or have you had any disease, condition or problem not listed above? Yes No

If so, please explain: _____

List medications you are currently taking: _____

Pharmacy name: _____ Telephone#: _____

Do you need antibiotic premedication prior to dental visits? Yes No

If so, please list the condition: _____

List allergies to any medication or substance:

- aspirin codeine latex local anesthetic penicillin sulfa
- other: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered every question on this form completely and accurately, to the best of my knowledge. I will inform my dentist of any change in my health and/or medication.

Patient signature: _____ Date: _____

*****Refer a patient to our practice and you will receive a \$100.00 credit toward your next treatment. This offer cannot be combined with another offer. *****