Dental Solutions of Northboro
367 West Main Street - Northboro, MA 01532
Tel: (508) 393-4777 - Fax: (508) 393-3456

Patient's Name: _____ Date of Birth: _____

PATIENT MEDICAL HISTORY

Physician's name: _____ Phone: _____
Physician's address: _____

In case of emergency notify: _____ Relationship: _____
Emergency contact phone: _____

Are you allergic to any of the following?
Circle Y for yes or N for no

Y N Aspirin
Y N Ibuprofen
Y N Sulfa Drugs/Sulfites/Sulfides
Y N Penicillin
Y N Codeine
Y N Latex
Y N Metals, Plastics
Y N Local Anesthetics (Novocaine)
Y N Other Medications - Which ones? _____
_____

Please answer the following questions:
Circle Y for yes or N for no

Y N Have you been asked by your medical doctor to premedicate before any dental treatment?
Y N I have taken prescribed medication for the prevention of osteoporosis (e.g.: Fosimax, Boniva, etc.)
Y N I smoke or use tobacco. If yes, how much per day? _____ How many years? _____
Y N WOMEN ONLY: Are you taking birth control medication?
Y N WOMEN ONLY: Are you or could you be pregnant or nursing?

Check any of the following that you HAVE HAD or HAVE at present:

- o Heart Disease or Attack
- o High Blood Pressure
- o Congenital Heart Lesions
- o Heart Pacemaker
- o Stent or Artificial Valve – year of placement: _____
- o Infective Endocarditis
- o Stroke
- o Artificial Joints – year of placement: _____
- o Arthritis
- o Asthma
- o Bleeding Disorder
- o Hepatitis ___
- o AIDS or HIV
- o Diabetes
- o Epilepsy or Seizures
- o Kidney Trouble
- o Liver Disease
- o Anemia
- o Herpes
- o Psychiatric Treatment
- o Sinus Trouble
- o Cancer
- o Chemotherapy
- o Radiation Treatment
- o Drug Addictions
- o Hearing Loss
- o Other: _____
_____

Do you have any other medical problems or medical history NOT listed on this form? _____
_____

Please list all medications you are currently taking:

Medicine: _____ Condition: _____
Medicine: _____ Condition: _____
Medicine: _____ Condition: _____
Medicine: _____ Condition: _____
Medicine: _____ Condition: _____
Medicine: _____ Condition: _____
Medicine: _____ Condition: _____
Medicine: _____ Condition: _____
Medicine: _____ Condition: _____

PATIENT DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.)
_____
Previous Dentist: _____
Last Visit: _____ Date of last cleaning: _____
What problems have you had with past dental treatment? _____
_____
Are you nervous about seeing a dentist? ☐ Yes! ☐ No
If yes, please tell us why: _____
_____

Please circle Y for yes or N for no

Y N I clench or grind my teeth – day or night.
Y N My gums feel tender or swollen
Y N My gums bleed while brushing or flossing.
Y N I have had orthodontics.
Y N I have had a facial or jaw injury.
Y N I avoid brushing part of my mouth due to pain.
Y N I want my teeth straight.
Y N I want my teeth whiter.
Y N I prefer tooth-colored fillings.

What are your dental priorities? *(e.g.: appearance, dental health, financial considerations, etc.)* _____
_____

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

Signature: _____ Date: _____
(Patient, legal guardian or authorized agent of patient)

Dentist/Hygenist Signature: _____ Date: _____

ACCOUNT INFORMATION

RESPONSIBLE PARTY FOR THIS ACCOUNT	**NAME:** LAST	FIRST	MIDDLE	HOME PHONE	CELL PHONE
	STREET	CITY		STATE	ZIP
	DATE OF BIRTH			SOCIAL SECURITY NUMBER	
EMPLOYER'S NAME AND ADDRESS	NAME			BUSINESS PHONE	
	STREET	CITY		STATE	ZIP

PAYMENTS TO BE MADE BY	DENTAL INSURANCE	CARRIER NAME	POLICY NUMBER
	CO-DENTAL INSURANCE	CARRIER NAME	POLICY NUMBER
	MEDICAL INSURANCE	CARRIER NAME	POLICY NUMBER

PATIENT INFORMATION

PATIENT NAME		SEX	M	F	Date of BIRTH	Mon	Day	Yr	MARITAL STATUS	S	M	W	D	WEIGHT		
PREVIOUS DENTIST NAME							Social Security Number							HEIGHT		
PHYSICIAN'S NAME																

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

PATIENT CONSENT FOR NO CHANGES IN PERSONAL HEALTH OR MEDICAL HISTORY

X _____
Patient/Guardian signature Date

X _____
Patient/Guardian signature Date

X _____
Patient/Guardian signature Date

X _____
Patient/Guardian signature Date

X _____
Patient/Guardian signature Date

X _____
Patient/Guardian signature Date