

TODAY'S DATE \_\_\_\_\_

DAVID DEAN D.M.D.  
1138 RIVER STREET  
HYDE PARK, MA. 02136-2917

DATE OF BIRTH \_\_\_\_\_

MR.\MRS.\MS. \_\_\_\_\_

TELEPHONE: HOME \_\_\_\_\_ BUS \_\_\_\_\_ CELL \_\_\_\_\_

ADDRESS \_\_\_\_\_

SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ DIVORCED \_\_\_\_\_ WIDOWED \_\_\_\_\_

ZIP CODE \_\_\_\_\_

SPOUSE EMPLOYE BY \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

PATIENT EMPLOYED BY \_\_\_\_\_

SPOUSE'S SOCIAL SECURITY # \_\_\_\_\_

PRESENT POSITION \_\_\_\_\_

IN CASE OF EMERGENCY, WHOM DO WE CONTACT? \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

PATIENT SOCIAL SECURITY # \_\_\_\_\_

HOW DO YOU GET TO THIS OFFICE? (CIRCLE ONE)

WHO WILL BE RESPONSIBLE FOR THIS ACCOUNT? \_\_\_\_\_

CAR BUS TAXI WALK OTHER \_\_\_\_\_

BEST TIME FOR AN APPOINTMENT: DAY \_\_\_\_\_ TIME \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_

BEST TIME OF DAY TO CALL - M T W TH F S TIME \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_

WOULD YOU BE AVAILABLE ON SHORT NOTICE IF THERE IS A CANCELLATION? ( Y / N )

GROUP NUMBER \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

SUBSCRIBER NUMBER \_\_\_\_\_

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. **THE PATIENT IS RESPONSIBLE FOR ALL FEES**, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. I UNDERSTAND THE PAYMENT POLICY AS STATED.

\_\_\_\_\_  
Signed (Patient, or parent of minor)

PURPOSE OF THIS VISIT ? \_\_\_\_\_

HOW LONG SINCE YOU HAVE BEEN TO A DENTIST? \_\_\_\_\_ WHO ? \_\_\_\_\_

WHAT WAS DONE THERE ? \_\_\_\_\_

Y N DID YOU HAVE X-RAYS?  
Y N DID YOU MAKE REGULAR VISITS BEFORE THEN?  
Y N HAVE YOU EVER HAD COMPLICATIONS WITH EXTRACTIONS?  
Y N DID YOU EVER NEED A ROOT CANAL?

Y N DO YOU SNACK BETWEEN MEALS?  
Y N ARE YOUR TEETH SENSITIVE TO HEAT?  
Y N ARE YOUR TEETH SENSITIVE TO COLD?  
Y N ARE YOUR TEETH SENSITIVE TO SWEETS?

HAVE YOUR TEETH EVER BEEN REPLACED BY:  
Y N A FIXED BRIDGE?  
Y N A DENTURE?  
Y N A REMOVABLE PARTIAL?

HOW OFTEN DO YOU BRUSH YOUR TEETH ? \_\_\_\_\_

DO YOU FLOSS ? \_\_\_\_\_

Y N IS YOUR BREATH SOMETIMES OFFENSIVE?  
Y N DOES FOOD COLLECT BETWEEN YOUR TEETH?  
Y N DO YOU EAT SWEETS OFTEN?

HOW DO YOU FEEL ABOUT YOUR TEETH ? \_\_\_\_\_

WHAT CAN WE DO TO MAKE YOUR TEETH BETTER ? \_\_\_\_\_

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(617) 361-5020

IN ORDER TO HELP US RENDER THE PROPER DENTAL SERVICES TO YOU, WOULD YOU PLEASE BE KIND ENOUGH TO ANSWER THE FOLLOWING QUESTIONS. PLEASE NOTE THE SPACE FOR REMARKS FOR ANY ANSWERS THAT REQUIRE CLARIFICATION OR ANY OTHER INFORMATION YOU THINK WE SHOULD HAVE. THANK YOU FOR YOUR COOPERATION.

PATIENT'S NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

GENERAL HEALTH (PLEASE CIRCLE)    EXCELLENT    GOOD    FAIR    POOR

NAME AND ADDRESS OF PHYSICIAN: \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

LAST COMPLETE PHYSICAL \_\_\_\_\_

ARE YOU UNDER THE CARE OF A PHYSICIAN NOW? \_\_\_\_\_ IF SO, FOR WHAT? \_\_\_\_\_

ARE YOU TAKING ANY MEDICATION NOW? \_\_\_\_\_ FOR WHAT PURPOSE? \_\_\_\_\_

PLEASE LIST MEDICATIONS YOU ARE TAKING:

\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU EVER BEEN TREATED FOR:

Y	N	HEART DISEASE	Y	N	FAINING OR SEIZURES
Y	N	RHEUMATIC FEVER	Y	N	CONGENITAL HEART LESIONS
Y	N	RHEUMATIC HEART DISEASE	Y	N	HEART MURMUR
Y	N	ABNORMAL BLOOD PRESSURE <b>HIGH/LOW</b>	Y	N	JAUNDICE
Y	N	ULCERS	Y	N	ASTHMA OR HAY FEVER
Y	N	TUBERCULOSIS OR LUNG DISEASE	Y	N	SINUS TROUBLE
Y	N	MENTAL OR NERVOUS DISORDERS	Y	N	THYROID PROBLEMS
Y	N	VENEREAL DISEASE	Y	N	HEPATITIS
Y	N	DIABETES	Y	N	ARTHRITIS
Y	N	EPILEPSY	Y	N	STROKE
Y	N	ANEMIA	Y	N	PSYCHIATRIC TREATMENT
Y	N	HIVES OR SKIN RASH	Y	N	GLAUCOMA
Y	N	KIDNEY PROBLEMS	Y	N	LIVER DISEASE
Y	N	HERPES INFECTION	Y	N	AIDS
Y	N	JOINT REPLACEMENT	Y	N	HIV INFECTION

DO YOU HAVE ANY **MEDICAL PROBLEMS**? (Y/N) EXPLAIN. \_\_\_\_\_

ARE YOU **ALLERGIC** TO (PLEASE CIRCLE IF YES)    PENICILLIN    CODEINE    LOCAL ANESTHETICS    ASPIRIN

ANY OTHER \_\_\_\_\_

ARE YOU SUBJECT TO PROLONGED BLEEDING? \_\_\_\_\_

DO YOU HAVE TROUBLE SLEEPING? \_\_\_\_\_ DO YOU HAVE DIGESTION PROBLEMS? \_\_\_\_\_

DO YOU SMOKE? \_\_\_\_\_ HOW MUCH? \_\_\_\_\_

HAVE YOU HAD ANY **SERIOUS OPERATIONS** IN THE LAST FIVE YEARS? \_\_\_\_\_

WOMEN

ARE YOU PREGNANT \_\_\_\_\_ HOW FAR ALONG? \_\_\_\_\_ ARE YOU NURSING? \_\_\_\_\_

DO YOU HAVE ANY PROBLEMS ASSOCIATED WITH YOUR MENSTRUAL PERIOD? \_\_\_\_\_

ARE YOU TAKING BIRTH CONTROL PILLS? \_\_\_\_\_

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT THE INQUIRIES SET FOURTH ABOVE HAVE BEEN ANSWERED TO MY SATISFACTION. I WILL NOT HOLD MY DENTIST, OR ANY MEMBER OF HIS/HER STAFF, RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM, AND I AGREE TO NOTIFY THE OFFICE OF ANY CHANGES.

\_\_\_\_\_  
Signed (Patient, or parent of minor)

(OVER)