Medway Family Dental

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

E-Mail _____ SS # _____ Birthdate _____

Check Appropriate Box: □ Minor □ Single □ Married □ Separated □ Divorced □ Widowed

If Student, Name of School/College _____ City _____ State _____

Patient's or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____Relationship to Patient _____

Address _____ Home Phone _____

E-Mail _____ Cell Phone _____

Driver's License # _____ Birthdate_____

Employer _____ Work Phone _____ SS # _____

Is this Person Currently a Patient in our Office? □ Yes □ No

For your convenience, we offer the following methods of payment. Please Payment is due in full at each appointment.

Cash – CareCredit – All Major Credit Cards

Patient Dental History

Name of Previous Dentist and Location _____ Date of last dental exam? _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	□	□
2. Are your teeth sensitive to hot or cold liquids/foods?	□	□
3. Are your teeth sensitive to sweet or sour liquids/foods?	□	□
4. Do you feel pain to any of your teeth?	□	□
5. Do you have any sores or lumps in or near your mouth?	□	□
6. Have you had any head, neck or jaw injuries?	□	□
7. Do you have frequent headaches?	□	□
8. Have you ever experienced any of the following problems in your jaw?		
Clicking	□	□
Pain (joint, ear, side of face)	□	□
Difficulty in opening or closing	□	□
Difficulty in chewing.	□	□
Do you clench or grind your teeth?	□	□
Do you bite your lips or cheeks frequently?	□	□
9. Are you in pain now?	□	□

	Yes	No
10. Have you ever had any difficult extractions in the past?	□	□
11. Have you ever had any prolonged bleeding following extractions?	□	□
12. Have you had any orthodontic treatment?	□	□
13. Do you wear dentures or partials?	□	□
If yes, date of placement _____		
14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	□	□
15. Do you like your smile?	□	□
16. Do you have dry Mouth?	□	□

Patient Health History

1. Is your general health good? _____
2. Has there been a change in your health within the last year? _____
3. Have you been hospitalized or had a serious illness in the last three years? _____
4. Are you being treated by a physician now? For What? _____
   Date of last medical exam? _____
5. Have you had problems with prior dental treatment? _____

Have you experienced	Yes	No		Yes	No
Chest pain (angina)?	□	□	Headaches?	□	□
Shortness of breath?	□	□	Fainting spells and/or vertigo?	□	□
Recent weight loss?	□	□	Blurred vision?	□	□
Persistent cough, coughing up blood?	□	□	Seizures?	□	□
Bleeding problems, bruising easily?	□	□	Excessive thirst?	□	□
Sinus problems?	□	□	Gastrointestinal problems?	□	□
Difficulty swallowing?	□	□	Jaundice?	□	□
Aphthous ulcers/canker sores?	□	□	Dizziness?	□	□

Do you have:	Yes	No		Yes	No
Heart disease/heart defects?	□	□	Hepatitis, other liver disease?	□	□
Congenital heart problems?	□	□	Stomach problems, ulcers?	□	□
Mitral valve prolapses?	□	□	Sexually transmitted disease?	□	□
Prosthetic heart valve?	□	□	AIDS/HIV infection?	□	□
Rheumatic fever?	□	□	Herpes/cold sores?	□	□
Stroke, hardening of arteries?	□	□	Tumors, cancer?	□	□
Artificial joint/metal?	□	□	Arthritis, rheumatism?	□	□
High blood pressure?	□	□	Eye diseases?	□	□
Low blood pressure?	□	□	Skin diseases?	□	□
Hypoglycemia?	□	□	Anemia?	□	□
Diabetes?	□	□	Kidney, bladder disease?	□	□
Asthma?	□	□	Thyroid, adrenal disease?	□	□
TB, emphysema, other lung diseases or persistent cough?	□	□	Eating disorders?	□	□
Do you have or have you ever had :	**Yes**	**No**		**Yes**	**No**
Psychiatric care?	□	□	Blood transfusions?	□	□
Radiation treatments?	□	□	Surgeries?	□	□
Chemotherapy?	□	□	Contact lenses?	□	□
Pacemaker?	□	□	**Have you ever taken Fosamax, Boniva, Actonel or any medication**		
Hospitalization?	□	□	**containing bisphosphonates?**	□	□

Are you allergic any of the following:	Yes	No	Are you taking:	Yes	No
Local Anesthetics (e.g. Novocaine)?	□	□	Recreational drugs?	□	□
Antibiotics?	□	□	Controlled substances?	□	□
If so, which ones? _____			Drugs, medications, over-the-counter medicines		
Sulfa Drugs?	□	□	(including Aspirin), natural remedies?	□	□
Barbiturates?	□	□	Blood thinners (such as Coumadin or Warfarin)?	□	□
Sedatives?	□	□	Medications for opiate dependency?	□	□
Iodine?	□	□	Tobacco in any form?	□	□
Aspirin?	□	□	Alcohol?	□	□
Any Metals (e.g. nickel, mercury, etc.)?	□	□	**PLEASE LIST ALL MEDICATIONS** _____		
Latex Rubber?	□	□	_____		
Other? _____			_____		
			_____		
			_____		

Women only:	Yes	No	All patients:	Yes	No
Are you or could you be pregnant?	□	□	**Do you have or have you had any other diseases or medical**		
Taking birth control pills?	□	□	**problems** NOT **listed on this form? (Example, ADHD, Depression,**		
Breast-feeding?	□	□	**Learning Disabilities)** If so, please explain:	□	□
			_____		
			_____		
			_____		
			_____		

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____Date _____

Hygienist or Doctor Comments :

_____

_____

_____

Doctor Signature_____ Date_____

Hygienist Signature_____ Date_____