

### Thank You for Selecting Our Dental Team.

To help us meet all your healthcare needs, please fill out this form completely. If you have any questions or need assistance, please call us at (978) 449-9919, option 1, and we will be happy to help.

Chart #:

FOR OFFICE USE ONLY

Patient Name: \*  Last \*  First  MI  Preferred Name

Title:  Mr/Ms/Mrs/etc Gender: \*  Male  Female Family Status: \*  Married  Single  Child  Other

Birth Date: \*  SS #:  Prev. Visit:

Email Address:  Best time to call:

Phone: \*  Home  Work  Ext  Mobile  Fax  Other

Address: \*    
\*  City \*  State \*  Zip Code

The following is for:  the patient  the person responsible for payment

Employer Name:  Phone:

Address:    
 City  State  Zip Code

Spouse or Other Parent/Guardian.

Spouse or Other Parent/Guardian Employer and Phone Number.

If a Student, Name of College:

Please Select

Full Time     Part Time

Whom may we thank for referring you?

\*

Person to Contact in Case of Emergency:

\*

Emergency Contact Phone Number(s)

\*

### RESPONSIBLE PARTY

The following is for:  the patient's spouse     the person responsible for payment     neither-not applicable

Name:  Last     First     MI     Preferred Name

Title:  Mr/Ms/Mrs/etc    Gender:  Male     Female    Family Status:  Married     Single     Child     Other

Birth Date:     SS #:     Driver's License #:

Email Address:     Best time to call:

Phone:  Home     Work     Ext     Mobile     Fax     Other

Address:    
 City     State     Zip Code

Responsible Party Employer Name and Address

[Empty text box for Responsible Party Employer Name and Address]

Is this person currently a patient in our office?

Yes  No

For your convenience, we offer the following methods of payment. Please check the option(s) you prefer for payment in full at each appointment.

- Cash
- Visa
- American Express
- Care Credit
- Check
- Mastercard
- Discover
- I wish to discuss the office's payment policy

**DENTAL INSURANCE INFORMATION**

Name of Insured: [Last] [First] [MI]

Insured's Birth Date: [ ] ID #: [ ] Group #: [ ]

Insured's Address: [ ] [ ] [City] [State] [Zip Code]

Insured's Employer Name: [ ]

Employer Address: [ ] [ ] [City] [State] [Zip Code]

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name: [ ]

Insurance Address: [ ] [ ] [City] [State] [Zip Code]

Do you have any additional dental insurance? (If Yes, please complete the following:)

Yes  No

Name of Insured:     
Last First MI

Insured's Birth Date:  ID #:  Group #:

Insured's Address:    
    
City State Zip Code

Insured's Employer Name:

Employer Address:    
    
City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name:

Insurance Address:    
    
City State Zip Code

## PATIENT MEDICAL HISTORY

Name of Primary Care Physician, City/State, Phone

Name of Other Health Care Provider/Advisor, City/State, Phone

Date of Last Full Physical Exam (month/year)

Are you under medical care now?

Yes  No

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?

Yes  No

If yes, please explain:

Are you taking any medications?

Yes  No

If yes, please list:

Do you take vitamins or supplements?

Yes  No

If yes, please list:

How would you describe your general health?

- Good     Fair     Poor

If your health is fair to poor, when was the last time you felt good?

Do you have frequent colds/flu?

- Yes     No

Do you exercise?

- Yes     No

How much water do you drink daily?

What do you drink besides water?

Do you drink diet soda or use artificial sweeteners?

- Yes     No

Do you use tobacco?

- Yes     No

Do you use controlled substances?

- Yes     No

Do you use alcohol?

- Yes     No

Are you wearing contact lenses?

- Yes     No

Have you ever taken Fen-Phen/Redux?

- Yes     No

Are you allergic to, or have you had any reactions to, the following: (Please check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Local Anesthetics (e.g., Novocaine)      | <input type="checkbox"/> Penicillin or any other Antibiotics |
| <input type="checkbox"/> Sulfa Drugs                              | <input type="checkbox"/> Barbiturates                        |
| <input type="checkbox"/> Sedatives                                | <input type="checkbox"/> Gluten                              |
| <input type="checkbox"/> Iodine                                   | <input type="checkbox"/> Aspirin                             |
| <input type="checkbox"/> Any Metals (e.g., nickel, mercury, etc.) | <input type="checkbox"/> Latex rubber                        |
| <input type="checkbox"/> Other                                    |  |

If Other, please explain

**WOMEN ONLY:**

Please check all that apply

- |   |                                  |
|---|----------------------------------|
| <input type="checkbox"/> Pregnant or do you think you may be pregnant | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Taking oral contraceptives                   |                                  |

Do you have, or have you had, any of the following: (Check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> High Blood Pressure             | <input type="checkbox"/> Low Blood Pressure           |
| <input type="checkbox"/> Heart Disease                   | <input type="checkbox"/> Cardiac Pacemaker            |
| <input type="checkbox"/> Rheumatic Fever                 | <input type="checkbox"/> Heart Murmur                 |
| <input type="checkbox"/> Mitral Valve Prolapse           | <input type="checkbox"/> Chest Pain                   |
| <input type="checkbox"/> Heart Attack                    | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Swollen Ankles                  | <input type="checkbox"/> Kidney Disease               |
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Hay Fever/Allergies          |
| <input type="checkbox"/> Respiratory Problems            | <input type="checkbox"/> Easily Winded                |
| <input type="checkbox"/> Emphysema                       | <input type="checkbox"/> Asthma                       |
| <input type="checkbox"/> Frequently Tired                | <input type="checkbox"/> Thyroid Problems             |
| <input type="checkbox"/> Fainting/Seizures               | <input type="checkbox"/> Epilepsy/Convulsions         |
| <input type="checkbox"/> Neurological Problems           | <input type="checkbox"/> Leukemia                     |
| <input type="checkbox"/> Anemia                          | <input type="checkbox"/> Cancer                       |
| <input type="checkbox"/> Radiation Therapy               | <input type="checkbox"/> Arthritis                    |
| <input type="checkbox"/> Fibromyalgia                    | <input type="checkbox"/> Joint Replacement/Implant    |
| <input type="checkbox"/> Multiple Chemical Sensitivities | <input type="checkbox"/> Frequent Headaches/Migraines |
| <input type="checkbox"/> Hepatitis/Jaundice              | <input type="checkbox"/> Liver Disease                |
| <input type="checkbox"/> Stomach Troubles/Ulcers         | <input type="checkbox"/> Diarrhea/Constipation        |
| <input type="checkbox"/> Aids or HIV Infection           | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Recent Weight Loss/Gain         | <input type="checkbox"/> Glaucoma                     |
| <input type="checkbox"/> Tuberculosis                    |   |

## PATIENT DENTAL HISTORY

Name of Current/Previous Dentist, City/State

Date of Last Exam (mm/year)

Date of Last X-rays (mm/year)

Date of Last Cleaning (mm/year)

Frequency of Cleaning

How often do you brush?

Is your toothbrush

manual     electric

Toothbrush Brand

Do you floss?

Yes     No

Do you use an oral irrigator?

Yes     No

Brand of oral irrigator if used:

Which toothpaste do you use?

Which mouthwash do you use?

Have you ever received oral hygiene instruction regarding the care of your teeth and gums?

Yes  No

Do your gums bleed while brushing or flossing?

Yes  No

Do you feel pain in any of your teeth?

Yes  No

Are your teeth sensitive to:

hot  cold  sweet  pressure

Have you had any of the following? (Please check all that apply.)

- |  |   |
|--|---|
| <input type="checkbox"/> Head, neck, or jaw injuries     | <input type="checkbox"/> Any sores or lumps in or near your mouth |
| <input type="checkbox"/> Problems in your jaw            | <input type="checkbox"/> Clicking                                 |
| <input type="checkbox"/> Pain (joint, ear, side of face) | <input type="checkbox"/> Difficulty opening or closing            |
| <input type="checkbox"/> Difficulty chewing              | <input type="checkbox"/> Frequent headaches                       |

Do you clench or grind your teeth?

Yes  No

Have you ever worn a nightguard or other appliance?

Yes  No

Do you wear one now?

Yes  No

Do you bite your lips or cheeks frequently?

Yes  No

Have your wisdom teeth been extracted?

Yes  No

If Yes, how did it heal?

Have you had any other difficult extractions?

- Yes  No

Have you ever had any prolonged bleeding following extractions?

- Yes  No

Have you ever had any orthodontic treatment?

- Yes  No

Do you wear retainers?

- Yes  No

Do you wear dentures or partials?

- Yes  No

If Yes, how old are they?

Do you like your smile?

- Yes  No

Are you concerned about the mercury amalgam silver fillings in your teeth?

- Yes  No

Has your mercury level ever been tested?

- Yes  No

If so, by what method?

If not, are you interested in testing your mercury level?

- Yes  No

Are you working with your physician or complementary provider to detox?

- Yes  No

If yes, please list provider's name and address:

## 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 payers and/or health practitioners. I authorize and request my insurance company to pay benefits directly to me, unless I am insured by Delta Dental Premier, in which case I authorize benefits to be payable to Groton Wellness. 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 that of my dependents.

I acknowledge receipt of the practices privacy notice.

Please type your initials here as acknowledgment of the above statement. (You will be required to sign this once you arrive at our office.)

\*

Response Date: