NASHOBA
FAMILY DENTISTS

Date_____

## Patient Information

Name _____ Birthdate _____ SS# _____ □ Male □ Female

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

Check Appropriate Box ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employer _____ Occupation _____ Work Phone _____

Emergency Contact Person _____ Phone _____

Student Status _____ School _____

Person responsible for account _____ Referred by _____

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## Dental Insurance

**Primary Insurance**

Name of Insured _____

Date of Birth _____

Relationship to Patient _____

Insurance Company Name _____

Employer _____

ID/SS # _____ Group # _____

**Secondary Insurance**

Name of Insured _____

Date of Birth _____

Relationship to Patient _____

Insurance Company Name _____

Employer _____

ID/SS # _____ Group # _____

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## Dental History

Previous dentist & location _____ Date of last exam _____

How often do you floss? _____ How often do you brush? _____

Have you had any problems associated with previous dental treatment? _____

Please check all that apply:

☐ Bad Breath
☐ Bleeding Gums
☐ Frequent Headaches
☐ Jaw, Head, or Neck Injuries
☐ Sensitivity to Hot
☐ Dry Mouth
☐ Loose Teeth or Broken Fillings
☐ Orthodontic Treatment
☐ Finger Nail Biting
☐ Grinding Teeth
☐ Sensitivity to Cold
☐ Dentures/Partials
☐ Sensitivity to Sweets or Biting
☐ Blisters on Lips or Mouth
☐ Periodontal Treatment
☐ Lip or Cheek Biting
☐ Tooth Pain

## Health History

Physician's Name _____ Date of Last Visit _____

Check the Appropriate Answer:

☐ Yes ☐ No Are you currently under medical treatment? If yes, explain _____

☐ Yes ☐ No Are you taking any medications now? If yes, explain _____

☐ Yes ☐ No Have you had any serious illness or operations? If yes, explain _____

☐ Yes ☐ No Do you smoke or drink alcohol? If yes, how often _____

☐ Yes ☐ No Do you need to pre-medicate for dental procedures? If yes, specify condition _____

☐ Yes ☐ No Do you have any allergies?

☐ Local Anesthetics ☐ Penicillin ☐ Latex ☐ Sulfa Drugs
☐ Aspirin ☐ Iodine ☐ Metals/Jewelry ☐ Sedatives
☐ Other, please specify: _____

Women Only: Are you Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Please check all that apply:

☐ High Blood Pressure
☐ Rheumatic Fever
☐ Sinus Trouble
☐ Swollen Ankles
☐ Fainting/Seizures
☐ Asthma
☐ Low Blood Pressure
☐ Epilepsy/Convulsions
☐ Leukemia
☐ Diabetes
☐ Kidney Disease
☐ Eating Disorder
☐ Angina
☐ Heart Murmur
☐ Other _____

☐ Thyroid Problem
☐ Frequently Tired
☐ Severe Headache/Migraines
☐ Anemia
☐ Emphysema
☐ Cancer
☐ Arthritis
☐ Joint Replacement/Implant
☐ AIDS or HIV Infection
☐ Hepatitis/Jaundice
☐ STD _____
☐ Osteoporosis
☐ Heart Attack
☐ Mitral Valve Prolapse

☐ Chest Pains
☐ Hay Fever Allergies
☐ Sleep Apnea/Snoring
☐ Stroke
☐ Tuberculosis
☐ Radiation Therapy
☐ Glaucoma
☐ Recent Weight Loss
☐ Liver Disease
☐ Respiratory Problems
☐ Stomach Trouble/Ulcer
☐ Reflux/Persistent heartburn
☐ Heart Disease
☐ Cardiac Pacemaker

Please initial if nothing is checked _____

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## 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 my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me or services rendered. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges not covered by my insurance company.

Patient or Guardian Signature _____ Date _____