NORTHBRIDGE

SMILES

1167 PROVIDENCE RD WHITINSVILLE MA 01588
(508) 444 0110

Patient Information

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

D.O.B: _____ Social Security #: _____

Sex: [ ] Male [ ] Female Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed

E-mail: _____

Responsible Party

(If patient is under 18)

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

D.O.B: _____ Social Security #: _____

Sex: [ ] Male [ ] Female Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed

E-mail: _____

Primary Insurance Information

Name of Policy Holder: _____ Relationship to Patient: [ ] Self [ ] Spouse [ ] Child

Social Security #: _____ Policy Holder D.O.B: _____

Insurance Company: _____ Employer: _____

Member ID: _____ Group #: _____

How did you hear about our office? _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If Yes, please explain: _____

Have you ever been hospitalized? Yes No If Yes, please explain: _____

Have you ever had a serious head/neck injury? Yes No If Yes, please explain: _____

Are you taking any medications or drugs? Yes No Please list: _____

Do you use tobacco? Yes No If Yes, please explain: _____

Do you use controlled substances? Yes No

Women: Pregnant/Trying to get Pregnant? Yes No Nursing? Yes No Taking oral contraceptives? Yes No

Are you allergic to any of the following?

[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Acrylic [ ] Metal [ ] Latex [ ] Local Anesthetics

[ ] Other: _____

Do you have, or have you had, any of the following:

AIDS/HIV Positive	Yes No	Drug/Alcohol Addiction	Yes No	Lung Disease	Yes No
Anaphylaxis	Yes No	Emphysema	Yes No	Mitral Valve Prolapse	Yes No
Anemia	Yes No	Epilepsy or Seizures	Yes No	Pain in Jaw Joints	Yes No
Angina	Yes No	Excessive Bleeding	Yes No	Parathyroid Disease	Yes No
Arthritis/Gout	Yes No	Fainting/Dizziness	Yes No	Psychiatric Care	Yes No
Artificial Heart Valve	Yes No	Frequent Cough	Yes No	Recent Weight Loss	Yes No
Artificial Joint	Yes No	Frequent Headaches	Yes No	Renal Dialysis	Yes No
Asthma	Yes No	Glaucoma	Yes No	Rheumatic Fever	Yes No
Blood Disease	Yes No	Heart Attack/Failure	Yes No	Rheumatism	Yes No
Blood Transfusion	Yes No	Heart Murmur	Yes No	Shingles	Yes No
Breathing Problem	Yes No	Heart Pacemaker	Yes No	Sickle Cell Disease	Yes No
Bruise Easily	Yes No	Heart Problem/Disease	Yes No	Sinus Problems	Yes No
Cancer	Yes No	Hepatitis A B C	Yes No	Stomach Disease	Yes No
Chemo/Radiation	Yes No	Herpes	Yes No	Stroke	Yes No
Chest Pains	Yes No	High/Low Blood Pressure	Yes No	Thyroid Disease	Yes No
Cold Sores/Fever Blisters	Yes No	Hypoglycemia	Yes No	Tonsillitis	Yes No
Congenital Heart Disorder	Yes No	Jaundice	Yes No	Tuberculosis	Yes No
Convulsions	Yes No	Kidney Problems	Yes No	Tumors or Growths	Yes No
Cortisone Medicine	Yes No	Leukemia	Yes No	Ulcers	Yes No
Diabetes	Yes No	Liver Disease	Yes No		

Have you ever had any serious illness not listed above? _____

Patient Name_____ Signature of Patient _____ Date_____

Signature of Dr. _____

(Parent if patient is a minor)