

1. Patient Information

Date _____ ID#/SS# _____

Patient _____

Address _____

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Occupation _____

Employer _____

Employer Address _____

Employer Phone (_____) _____

Spouse's Information:

Name _____

Birthdate _____ SS# _____

Occupation _____

Employer _____

Whom may we thank for referring you? _____

2. Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Newburyport Dental Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

3. Phone Numbers

Home _____ Work _____ Ext. _____ Cell _____

Best time & place to reach you _____

IN CASE OF EMERGENCY, CONTACT (specify someone who does not live in your household):

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4. Dental History

Reason for today's visit _____

Date of last dental exam _____ Date of last dental x-rays _____

Are you currently experiencing any pain or discomfort? Yes No

Are your teeth sensitive to temperature or pressure? Yes No

Do you have a dry mouth? Yes No

Have you had any problems associated with previous dental treatment? Yes No

Do you have any clicking, popping or discomfort in the jaw? Yes No

Do you brux or grind your teeth? Yes No

5. Medical Information

Physician's name _____ Phone # _____

Date of last exam _____

Has a physician or previous dentist recommended you take antibiotics prior to your dental treatment? Yes No

If yes, for what reason? _____

Please mark appropriate box with an (x) to indicate if you have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Previous Infective Endocarditis | <input type="checkbox"/> Rheumatic Heart Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis or Liver Disease |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Fainting Spells or Seizures |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Neurological Disorders |
| <input type="checkbox"/> Chest Pain upon exertion | <input type="checkbox"/> AIDS or HIV Infection | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes: | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Type I <input type="checkbox"/> Type II | <input type="checkbox"/> Severe Headaches / Migraines |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Systemic Lupus Erythematosus | <input type="checkbox"/> Gastrointestinal Disease | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcers | |

Women: Are you pregnant? Yes No Nursing? Yes No

Taking oral contraceptives? Yes No

- Are you taking or scheduled to be taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? Yes No
- Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aledia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes No Date treatment began: _____
- Do you use tobacco (cigarettes, snuff, chew, bidis)? _____ How much per day? _____

6. Medications

List any medications and supplements you are currently taking:

Pharmacy Name: _____ Phone: (_____) _____

7. Allergies

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbiturates (sleeping pills) | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Other: _____ |

Patient Signature _____ Dr. Signature _____ Date _____