Holliston Dental Associates

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

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

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 problems** NOT **listed on this form? (Example, ADHD, Depression, Learning Disabilities)** If so, please explain:	☐	☐
Taking birth control pills?	☐	☐	____		
Breast-feeding?	☐	☐	____		
			____		
			____		

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 :

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Doctor Signature____ Date________________________

Hygienist Signature____ Date________________________