Holliston Dental Associates

Welcome Thank you for selecting us.

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 (Confidential)

Patient Number _____

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 _____ ☐ Full Time ☐ Part Time

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 _____ Financial Institution _____

Employer _____ Work Phone _____ SS # _____

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 you prefer. Payment in full at each appointment.

☐ Cash Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last 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. 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	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐
17. Dry Mouth?	☐	☐

Over Please

Patient Health History

I. CHECK APPROPRIATE ANSWER (leave Blank if you do not understand question): Yes No

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? ☐ ☐
   If YES, why? _____
4. Are you being treated by a physician now? For What? ☐ ☐
   Date of last medical exam? _____ Date of last Dental exam? _____
5. Have you had problems with prior dental treatment? ☐ ☐
6. Are you in pain now? ☐ ☐

II. 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?	☐	☐			

III. DO YOU HAVE OR HAVE YOU HAD:	Yes	No		Yes	No
Heart disease/heart defects?	☐	☐	AIDS/HIV infection?	☐	☐
Congenital heart problems?	☐	☐	Tumors, cancer?	☐	☐
Mitral valve prolapse?	☐	☐	Arthritis, rheumatism?	☐	☐
Rheumatic fever?	☐	☐	Eye diseases?	☐	☐
Stroke, hardening of arteries?	☐	☐	Skin diseases?	☐	☐
High blood pressure or low blood pressure?	☐	☐	Anemia?	☐	☐
Asthma?	☐	☐	Sexually transmitted disease?	☐	☐
TB, emphysema, other lung diseases or persistant cough?	☐	☐	Herpes/cold sores?	☐	☐
Hepatitis, other liver disease?	☐	☐	Kidney, bladder disease?	☐	☐
Stomach problems, ulcers?	☐	☐	Thyroid, adrenal disease?	☐	☐
Hypoglycemia?	☐	☐	Diabetes?	☐	☐
Prosthetic heart valve?	☐	☐	Eating disorders?	☐	☐
Artificial joint/metal?	☐	☐			

IV. DO YOU HAVE OR HAVE YOU 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		
Hospitalization?	☐	☐	medication containing bisphosphonates?	☐	☐

V. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING:	Yes	No
Local Anesthetics (e.g. Novocain)?	☐	☐
Penicillin or other Antibiotics?	☐	☐
Sulfa Drugs?	☐	☐
Barbiturates?	☐	☐
Sedatives?	☐	☐
Iodine?	☐	☐
Aspirin?	☐	☐
Any Metals (e.g. nickel, mercury, etc.)?	☐	☐
Latex Rubber?	☐	☐
Other? _____	☐	☐

VI. ARE YOU TAKING:	Yes	No
Recreational drugs/controlled substances?	☐	☐
Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	☐	☐
Blood thinners (such as Coumadin or Warfarin)?	☐	☐
Please list: _____		
_____		
_____		
_____		
Tobacco in any form?	☐	☐
Alcohol?	☐	☐

VII. WOMEN ONLY:	Yes	No
Are you or could you be pregnant?	☐	☐
Taking birth control pills?	☐	☐
Breast-feeding?	☐	☐

VIII. ALL PATIENTS:

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: _____

_____

_____

_____

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 _____

Signature of patient (or parent if minor)

Doctor's Comments _____

_____

_____ Signature _____ Date _____