OFFICE USE ONLY: Acct. # _____

209 Brookline Dental

EXCEEDING EXPECTATIONS

Welcome.

We are glad that you have chosen to be here with us. We will strive to provide excellent dental care to meet your needs and concerns. As we are committed to serve you in a most efficient and timely manner for your each visit, please fill out the following questionnaire for your first visit.

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Patient Information

Today's Date _____/_____/ 2018

First: _____ Middle: _____ Last: _____ Jr/Sr: ____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Date of Birth: _____

Email Address: _____ May we contact you by email? **Yes / No**

Occupation: _____ Your Insurance: _____

Emergency Contact: _____ Relation to You: _____

Emergency Contact Phone: _____

For Today's Visit

Reason for today's Visit:

_____

_____

Have you seen another dentist in the past year? **Yes / No**

For what treatment? _____

Office Name & Phone: _____

Who may we thank for referring you to our practice? _____

Do you have other family members treated by our practice? _____

Insurance Information

Do you have Dental Insurance? **Yes / No**

Please bring your insurance card(s) so that we can copy any relevant information necessary to process your transactions efficiently.

209 Brookline Dental
EXCEEDING EXPECTATIONS

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Patient Medical Information

Today's Date _____/_____/ 2018

Your oral health is interrelated with your medical history. We need information on your medical history which may affect your treatment. Thank you for providing following information.

Patient's Name: _____

Physician's Name: _____ Office Phone: _____

Are you under a physician's care now?	**Yes / No**	If yes, please explain.
Have you ever been hospitalized?	**Yes / No**	
Have you ever had a serious head or neck injury?	**Yes / No**	
Are you currently taking any medications, pills, or drugs?	**Yes / No**	
Do you take, or have you taken, Phen-Fen or Redux?	**Yes / No**	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	**Yes / No**	
Have you been tested for Tuberculosis recently?	**Yes / No**	
Are you on a special diet?	**Yes / No**	
Do you use tobacco?	**Yes / No**	

Women: Are you on BCP's? **Yes / No** Are you pregnant? **Yes / No** Nursing? **Yes / No**

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you have, or have you had, any of the following in the past?

Abnormal Bleeding	Yes/No	Emphysema	Yes/No	Herpes or fever Blisters	Yes/No	Rheumatic Fever	Yes/No
Alcohol/Drug Abuse	Yes/No	Epilepsy or Seizures	Yes/No	High Blood Pressure	Yes/No	Shingles	Yes/No
Anemia	Yes/No	Fainting Spells / Dizziness	Yes/No	High Cholesterol	Yes/No	Sickle Cell Disease	Yes/No
Artificial Joint	Yes/No	Frequent Cough	Yes/No	Kidney Problems	Yes/No	Stroke	Yes/No
Asthma	Yes/No	Frequent Headaches	Yes/No	Leukemia	Yes/No	Thyroid Disease	Yes/No
Cancer	Yes/No	Glaucoma	Yes/No	Liver Disease	Yes/No	Tuberculosis (TB)	Yes/No
Colitis	Yes/No	Heart Attack	Yes/No	Pain in Jaw Joints	Yes/No	Ulcers	Yes/No
Coronary Artery Surgery	Yes/No	HIV / AIDS Stroke	Yes/No	Recurrent Sinus Infection	Yes/No	Venereal Disease	Yes/No
Diabetes	Yes/No	Hepatitis B or C	Yes/No	Radiation Treatments	Yes/No	Yellow Jaundice	Yes/No

Have you ever had any serious illness not listed? **Yes / No** If yes, please explain _____

How many times do you brush each day? _____ Floss each day? _____ Do you brush after meals? **Yes / No / Irregular**

OFFICE USE ONLY: Acct. # _____

Informed Consent for General Dental Procedures

[As required by the Commonwealth of Massachusetts 234 CMR 5.15: 3(f)1]

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre- and post- treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. **Treatment to be Provided**
   I understand that during my course of treatment that the following care may be provided: Examinations, Preventive Services including radiographs and cleanings, Restorations, Crowns, Bridges, and Other Services.

   Patient Initials _____

2. **Drugs and Medications**
   I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

   Patient Initials _____

3. **Changes in Treatment Plan**
   I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

   Patient Initials _____

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable.

   Patient Initials _____

5. I am aware of the "Notice of Privacy Practices,": a copy of which is available at the front desk.

Printed Name _____

Patient Signature _____ **Date** _____ / _____ / _____