Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire 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.

□ yes □ no *Are you under a physician's care now?* *If yes, please explain*_____
□ yes □ no *Have you ever been hospitalized or had a major operation?* *If yes, please explain*_____
□ yes □ no *Have you ever had a serious head or neck injury?* *If yes, please explain*_____
□ yes □ no *Are you taking any medications, pills, or drugs?* *If yes, please explain*_____
□ yes □ no *Do you take, or have you taken Phen-Fen or Redux?*
□ yes □ no *Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?*
□ yes □ no *Are you on a special diet?* *Vitamin supplements*_____
□ yes □ no *Do you use tobacco?*
□ yes □ no *Do you use controlled substances?* *Height* _____ *Weight* _____

Women: Are you pregnant/trying to get pregnant? □ yes □ no *Taking oral contraceptives?* □ yes □ no *Nursing?* □ yes □ no

Are you allergic to any of the following? □ **Aspirin** □ **Penicillin** □ **other antibiotics** _____
□ **Codeine** □ **Acrylic** □ **Metal** □ **Latex** □ **Iodine** □ **Local Anesthetics** □ **Sedatives** □ **Barbiturates** □ **Sulfa**
□ **other** _____ *No known allergies*_____ *(Initials required)*

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

AIDS/HIV Positive	□ Yes □ No	Fainting spells/Dizziness	□ Yes □ No	Osteoporosis	□ Yes □ No
Alzheimer's Disease	□ Yes □ No	Frequent cough	□ Yes □ No	Pain in Jaw Joints	□ Yes □ No
Anaphylaxis	□ Yes □ No	Frequent Diarrhea	□ Yes □ No	Parathyroid Disease	□ Yes □ No
Anemia	□ Yes □ No	Frequent Headaches	□ Yes □ No	Psychiatric Care	□ Yes □ No
Arthritis/Gout	□ Yes □ No	Genital Herpes	□ Yes □ No	Radiation Treatments	□ Yes □ No
Artificial Heart Valve	□ Yes □ No	Glaucoma	□ Yes □ No	Recent Weight Loss	□ Yes □ No
Artificial Joint	□ Yes □ No	Hay Fever	□ Yes □ No	Renal Dialysis	□ Yes □ No
Asthma	□ Yes □ No	Heart Attack/failure	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Blood Disease	□ Yes □ No	Heart Murmur	□ Yes □ No	Rheumatism	□ Yes □ No
Blood Transfusion	□ Yes □ No	Heart Pace Maker	□ Yes □ No	Scarlet Fever	□ Yes □ No
Breathing Problem	□ Yes □ No	Heart Trouble /disease	□ Yes □ No	Shingles	□ Yes □ No
Bruise Easily	□ Yes □ No	Hemophilia	□ Yes □ No	Sickle Cell Disease	□ Yes □ No
Cancer	□ Yes □ No	Hepatitis A	□ Yes □ No	Sinus Trouble	□ Yes □ No
Chemotherapy	□ Yes □ No	Hepatitis B or C	□ Yes □ No	Spina Bifida	□ Yes □ No
Chest Pains	□ Yes □ No	Herpes	□ Yes □ No	Stomach/Intestinal Disease	□ Yes □ No
Cold Sores/Fever Blisters	□ Yes □ No	High Blood Pressure	□ Yes □ No	Stroke	□ Yes □ No
Congenital Heart Disorder	□ Yes □ No	High Cholesterol	□ Yes □ No	Swelling of Limbs	□ Yes □ No
Convulsions	□ Yes □ No	Hives or Rash	□ Yes □ No	Thyroid Disease	□ Yes □ No
Cortisone Medicine	□ Yes □ No	Hypoglycemia	□ Yes □ No	Tonsillitis	□ Yes □ No
Diabetes	□ Yes □ No	Irregular Heartbeat	□ Yes □ No	Tuberculosis	□ Yes □ No
What is your A1C # _____		Kidney Problems	□ Yes □ No	Tumors or Growths	□ Yes □ No
Drug Addiction	□ Yes □ No	Leukemia	□ Yes □ No	Ulcers	□ Yes □ No
Easily Winded	□ Yes □ No	Liver Disease	□ Yes □ No	Venereal Disease	□ Yes □ No
Emphysema	□ Yes □ No	Low Blood Pressure	□ Yes □ No	Yellow Jaundice	□ Yes □ No
Epilepsy or Seizures	□ Yes □ No	Lung Disease	□ Yes □ No		
Excessive Bleeding	□ Yes □ No	Mitral Valve Prolapse	□ Yes □ No	Other _____	
Excessive thirst	□ Yes □ No				

*Name of previous Dentist and location*_____ *Date of last exam*_____
Do your gums bleed while brushing or flossing ? _____ *Are your teeth sensitive to hot or cold?* _____ *Frequent headaches?* _____
Are your teeth sensitive to sweet or sour foods? _____ *Do you clench or grind your teeth?* _____ *Do you feel pain to any of your teeth?* _____
Do you bite your lips or cheeks frequently? _____ *Have you ever had complications with any extractions?* _____ *Prolonged bleeding?* _____
Do you like your smile? _____ *Have you had orthodontic treatment?* _____ *Do you wear partials or dentures?* _____
Do you have any sores or lumps in or near your mouth? _____ *Have you had head, neck or jaw injuries?* _____
Have you ever experienced any of the following problems with your jaw: Clicking _____ *Pain (joint, ear, side of face)* _____ *Difficulty chewing* _____
Difficulty in opening or closing _____*?*

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 upon my request. 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 on my behalf or my dependents.

_____ _____
Signature of patient (or parent/guardian if minor) *Date*

Family Dentistry of Lowell

PATIENT INFORMATION

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):

Date: _____

Name_____ Birthdate_____

SS# _____-_____-_____ **Driver's License #** ____-_____-_____-_____-_____

Address_____ City _____ St _____ Zip _____

Home phone _____ Work phone _____ ext _____ Cell _____

E-mail address _____ *(Please print very carefully)*

Employer _____ Preferred Name _____

☐ Minor ☐ Single ☐ Married ☐ Widowed

How did you hear about our office? _____

Person to contact in case of an emergency _____ Phone _____

If patient is a minor:

Mother's Name_____
Birthdate_____
Employer_____
Work phone # _____
SS#_____

Father's Name_____
Birthdate_____
Employer_____
Work phone # _____
SS#_____

If college student, name of college_____ City _____ St____

☐ Full time ☐ Part time **Has student status been established with your insurance carrier? YES or NO**

Primary Dental Insurance Information

Name of Insured _____ DOB_____ Relationship to patient _____

SS#_____ Member ID#_____ (located on your ID card)

Insurance Carrier _____ Employer _____

Insurance Address _____City _____ St ____ Zip code _____

Insurance Phone # _____ Group # _____

Secondary Dental Insurance Information

Name of Insured _____ DOB_____ Relationship to patient _____

SS#_____ Member ID#_____ (located on your ID card)

Insurance Carrier _____ Employer _____

Insurance Address _____City _____St ____ Zip code _____

Insurance Phone # _____ Group # _____

(OVER)