Beacon Hill Dental Associates

PATIENT INFORMATION

Today's Date: _____

Patient: _____ Date of Birth: _____
Last First Middle Initial

How do you like to be addressed?

Gender: O Male O Female Social Security #:

Residential Address: _____
Street City State Zip Code

E-Mail Address: _____ Social Security No. _____

Home Tel. #: (_____) _____ Cell Business Tel.#: (_____)

#: (_____) _____ Fax #: (_____)

Employer: _____ Occupation: _____

Marital Status: O Single O Married O Partnered

Spouse or Partner Name: _____

Who is legally responsible if other than patient? _____
Name

By whom were you referred? _____

Do you have dental insurance? O Yes O No

FINANCIALLY RESPONSIBLE PARTY

Name: _____ Social Security #: _____

Address: _____
Street City State Zip Code

Home Tel. #: (_____) _____ Business Tel.#: (_____) _____

Relationship to Patient: O Spouse O Parent O Guardian O Other _____

Our office policy is that the parent or guardian who has requested treatment is responsible for all fees for services rendered.

Primary Insurance Information

Insurance Company Name and Address _____

Employee/Subscriber Name: _____ Social Security #: _____

Group # _____ Name of Employer with Telephone #: _____

Maximum Benefit for year: _____

EMERGENCY CONTACT

Person to contact in case of emergency: _____ Telephone: _____

Relationship to Patient: O Spouse O Parent O Guardian O Other _____

MEDICAL HISTORY

Please check YES or NO.

1. Do you have a current medical problem? O YES O NO

   If yes, please describe, _____

2. Are you currently under the care of a physician? O YES O NO

   If yes, please list, _____

3. Have you been hospitalized or had a serious illness within the past 5 years? O YES O NO

   If yes, please describe, _____

4. Do you have heart trouble or any form of cardiovascular disease? O YES O NO

   - O Angina (chest pains) Frequency _____
   - O Heart attack (date) _____
   - O Heart surgery (date) _____
   - O Pacemaker
   - O Bypass
   - O Prosthetic heart valve
   - O Stroke (Date) _____
   - O Rheumatic fever (date) _____
   - O Heart murmur
   - O High blood pressure
   - O Congenital heart lesions
   - O Atherosclerosis
   - O Mitral valve prolapse
   - O Other _____

5. Do you have diabetes? O YES O NO

6. Do you have any blood disease?

   O Anemia O AIDS or positive test O Leukemia O Venereal disease O Other_____

7. Do you have any problems with excessive bleeding? O YES O NO

   If YES, Please explain, _____

8. Do you have stomach or intestinal ulcers? O YES O NO

9. Have you ever had tuberculosis? (Date) _____ O YES O NO

10. Do you have emphysema, asthma or breathing problems? O YES O NO

11. Do you have any form of arthritis? O YES O NO

    O Rheumatoid Arthritis O Osteoarthritis O Gout/Gouty Arthritis O Other_____

    Which joints are involved? _____

12. Have you had a hip or other joint replacement? O YES O NO

13. Have you ever had any injury, pain or soreness from your jaw joint? (TMJ dysfunction) O YES O NO

14. Have you ever had any chronic head, neck, or back pain problems? O YES O NO

15. Have you ever suffered trauma to your head or neck, such as in a car accident? O YES O NO

    If YES, please describe, _____

16. Do you have fainting spells, convulsions or epilepsy? O YES O NO

17. Have you had surgery, radiation or other treatment for a tumor or growth? O YES O NO

    If YES, please describe, _____

18. Do you have glaucoma? O YES O NO

    O Right Eye O Left Eye O Both Eyes

19. Is your diet medically prescribed? O YES O NO

    If YES, please explain, _____

20. Are you pregnant? (Expected delivery date) _____ O YES O NO

MEDICAL HISTORY (cont.)

21. Do you take aspirin on a daily basis? O YES O NO

22. Have you reached menopause? O YES O NO
If YES, what hormones are you taking, if any? _____

23. Are you taking any calcium supplementation? O YES O NO

24. Other concerns you may want the doctor to know about: _____

The thoroughness of this medical history is designed for your safety, and your complete answers will assist us in treating you with consideration for your special needs.

DENTAL HEALTH

Reason for visit: _____

When was your last dental visit? _____ With whom: _____ City & State: _____

Have you ever had any serious problem associated with previous dental treatment? O YES O NO

have you ever had any serious problem associated with previous dental treatment? O YES O NO

If so, explain: _____

How often do you brush your teeth on a daily basis? _____

What texture brush do you use? O Soft O Medium O Hard O Nylon O Natural

Do you floss? O YES O NO How often? _____

Do your gums bleed when brushing? O YES O NO

Do your gums bleed when flossing? O YES O NO

Do you avoid brushing any part of your mouth because of pain? O YES O NO

If yes, what part? _____

Do you feel twinges of pain when your teeth come into contact with:

a) Hot foods or liquids, i.e. soup, coffee, tea, etc. ? O YES O NO

b) Cold foods or liquids, i.e. ice cream, cold fruit, etc. ? O YES O NO

c) Sweets, i.e. candy, fruit, sweet desserts, chocolates, etc. ? O YES O NO

Do your gums feel tender or swollen? O YES O NO

Do you clench or grind your teeth while sleeping or during the day? O YES O NO

Do your jaws ever feel sore or tired? O YES O NO

Do you wear: O Dentures O Retainers O Night Guard O Anti-Snore Device

Would you or anyone in your family be interested in using an anti-snore device? O YES O NO

Do you lose or break fillings easily? O YES O NO

Do you gag easily? O YES O NO

Are you familiar with “preventive dentistry”? O YES O NO

On a scale of 1 to 5: How happy are you with your smile? (please circle) (not happy) 1 2 3 4 5 (very happy)

How important are the cosmetics of your back teeth? (please circle) (don’t care) 1 2 3 4 5 (really care)

How much do you want to save your teeth? (please circle) (don’t care) 1 2 3 4 5 (really care)

Please add anything you feel is important: _____

MEDICATIONS

1. Are you taking any of the following medications?

O Sulfa drugs O Xylocaine O Other antibiotics _____ O Nitrous oxide

O Codeine O Epinephrine O Aspirin O Barbiturates O Sleeping pills

O Any other medications _____

O Any drug allergies? _____

2. Have you ever been advised not to take a particular medication? O YES O NO

If YES, please list _____

_____

3. Have you ever been advised to take prophylactic antibiotics before dental treatment? O YES O NO

4. Are you currently taking any medication? O YES O NO

Please indicate any medications you are taking

	Name	Purpose	Frequency	Since
O Heart Medication				
O Blood Pressure Medication				
O Nitroglycerine				
O Inderal				
O Antibiotics				
O Sedatives				
O Tranquilizers				
O Pain Medication				
O Cortisone (Steroids)				
O Thyroid				
O Birth Control Pills				
O Other Medications				

5. Please indicate amounts, if any, of the following:

O Alcohol (_____) drinks per day

O Tobacco (_____) packs per day for approximately (_____) years

O "Recreational" drugs such as cocaine, marijuana, stimulants or depressants may have a fatal interaction with local anesthetics or other common dental medications. Please describe the use of any drugs or discuss in complete confidentiality with the doctor. _____

_____

_____

APPOINTMENT POLICY: Our practice is dedicated to your quality treatment and is pleased to reserve the appropriate amount of time for your appointment. A 48 hour notice is however required for any change in an appointment.

To the best of my knowledge, all preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the dentist and office staff, and I will assume financial responsibility.

Signature _____ Date _____