210A South St. Unit 1

Plainville, MA 02762

Phone: (774)306-4094

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | |  | | | | | |  |  | | |  | |
| Patient Last Name | | Patient First Name | | | | | | M I | Preferred Name | | | Date (mm/dd/yy) | |
|  | | |  | | |  | | | |  | | | |
| Social Security # | | | Date of Birth | | | Gender | | | | Family Status | | | |
|  | | |  | | | | | | |  | | | |
| Phone (Mobile) | | | Phone (Home) | | | | | | | Phone (Work) | | | |
| Email |  | | | | Preferred contact | | | | |  | | | |
| Address |  | | | | | | | | | | Apt # | |  |
| City |  | | | State | | |  | | | ZIP |  | | |

HEALTH INFORMATION

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date of Last Visit: | | | | Reason for this Visit: | | |
| AIDS | | Tuberculosis | | | Kidney Disease | Dialysis |
| Respiratory Problems | | Asthma Do you carry an inhaler Yes No | | | | |
| How often do you use inhaler: | | | | |
| Thyroid Condition Hypothyroidsm Hyperthyroidsm | | | | | | |
| COPD Emphysema Bronchitis Sinus Problems | | | | | | |
| GI Problems GERD Ulcers Colitis | | | | | | |
| Liver Disease Hepatitis Type of Hepatitis: | | | | | | |
| Cancer Details: | | | | | | |
| Are you currently in treatment Yes No | | | | | | |
| History of Chemo: | | | History of Radiation therapy: | | | |
| Nervous Disorders | | History of Seizures: | | | | |
|  | | | | |
| Head and face injuries | | Details: | | | | |
|  | | | | |
| Heart Disease | |  | | | | |
|  | | | | |
|  | | | | |
| High Blood Pressure | | Pacemaker | | | Anemia | Fainting |
| Excessive Bleeding | | Arthritis | | | Rheumatic Fever | Rheumatism |
| Diabetes | | Glaucoma | | | Dizziness | Hay Fever |
| Stroke: | Details: | | | | | |
| Blood Disease: | Details: | | | | | |
| Mental Disorders: | Details: | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Pregnancy: Due Date: | mm/dd/yy | |  |  | Nursing: (Date (mm/dd/yy): | | | |
| Please list all surgeries with Dates (mm/dd/yy) | |  | | | | | | |
|  | | | | | | |
|  | | | | | | |
|  | | | | | | |
|  | | | | | | |
| Need for premed with antibiotics | | | Yes | No | Details: |  |  | |
| Allergies ... Latex Others please specify >> | |  | | | | | | |
|  | | | | | | |
|  | | | | | | |
|  | | | | | | |
|  | | | | | | | | |
| Have you ever had any complications following dental treatment? | | | | | | Yes | No |  |
| If yes, please explain: | | | | | | | | |

|  |  |  |
| --- | --- | --- |
| Have you been admitted to a hospital or needed care during the past two years ? | | Yes No |
| If yes, please explain: |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Physician: |  | Phone # |  |
| Do you have any health problems that need further clarification ? | | | Yes No |
| If yes, please explain: |  | | |

Please l ist all medications that you are taking, prescriptions and supplements:

|  |  |  |
| --- | --- | --- |
| Name of medicine | Reason | Dosage |
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To the best of my knowledge all of the preceding answers and information provided are true and correct If I ever have any change in my health I will inform the doctors at the next appointment, without fail

|  |  |
| --- | --- |
|  |  |
| Signature of Patient / Parent / Guardian | Date (mm/dd/yy) |

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