210A South St. Unit 1

Plainville, MA 02762

Phone: (774)306-4094

info@dentalartsofplainville.com

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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: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Pregnancy: Due Date: | mm/dd/yy |  |  | Nursing: (Date (mm/dd/yy): |
| Please list all surgeries with Dates (mm/dd/yy) |  |
|  |
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|  |
|  |
| Need for premed with antibiotics | Yes | No  | Details:  |  |  |
| Allergies ... Latex Others please specify >> |  |
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|  |
|  |
| 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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