Tewksbury Family Dental, LLC

www.tewksfamilydental.com
1120 Main Street • Tewksbury, MA 01876
shahidi2@verizon.net
(978)851-8888

About You

Chart#: _____ FOR OFFICE USE ONLY

Patient Name: _____ Last _____ First _____ MI

_____ Preferred Name

Title: **Gender:** _____ Mr/Ms/Mrs/etc ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____

SS#: ___-__-____

Prev. Visit: _____

Email Address: _____

Best time to call: _____

Phone: _____ Home _____ Mobile _____ Work _____ Ext

_____ Fax _____ Other

Address: _____ Address 1

_____ Address 2

_____ City _____ State _____-____ Zip Code

Whom may we thank for referring you to our practice?

_____

INFORMATION FOR PERSON IN THE FAMILY WHO IS THE INSURANCE CARRIER:

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____

Phone: _____

Employer Address: _____ Address 1

_____ Address 2

_____ City

_____ State _____-____ Zip Code

Medical History

Please take a moment to let us know about your medical history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

Your Primary Care Physician's name, address, & phone number:

_____

_____

What is the date (or approximate date) of your last medical exam?

_____

_____

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Do you use tobacco (smoking or chewing)?Drink alcohol?

If any of the previous questions are marked, please explain:

_____

_____

Have you ever taken Bisphosphonates, ie Fosomax, Boniva, Didronel? ◯ Yes ◯ No

Have you ever in your Life time had any ARTIFICIAL JOINTS, or any Joint Replacement? ◯ Yes ◯ No

Spouse's Name and Cell Phone number

_____

_____

Who may we contact in case of emergency?

_____

_____

Please indicate if you have experienced any of the following:

- ☐ *Pre-Med - Amox
- ☐ *Pre-Med - Clind
- ☐ *Pre-Med - Other
- ☐ Allergies
- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Erythro
- ☐ Allergy - Hay Fever
- ☐ Allergy - Latex
- ☐ Allergy - Other
- ☐ Allergy - Penicillin
- ☐ Allergy - Sulfa
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Other
- ☐ Over 18 Consent Form
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

Do you have any other conditions, diseases, etc., not listed above that we should be aware of? ◯ Yes ◯ No

Do you have any other health issues or allergies not listed above?

_____

_____

Are you taking any Medication? If so, please list below:

_____

_____

_____

_____

Dental History

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Also, just so you are aware starting Jan 2015, Massachusetts law requires all dentist to check Prescription Monitoring Program before Prescribing any controlled substance prescription medication.

Please sign the electronic ePad confirming you have read all form:

Relationship to Patient

Response Date: _____