WABAN DENTAL GROUP

ADULT MEDICAL AND DENTAL HISTORY

Date:___________

Name: ____Middle Initial: _____Suffix:______
(First) (Last)

Address: _________________________________City:________________ Zip Code: _________

Date of Birth: _____________ Gender: Male _____ Female_____ Home Phone: ______________

Cell Phone: ______________________________ Work Phone: _________________ Ext: ________

E:Mail : _______________________________Emergency Contact: _______________________

Preferred Communication for Appointment Reminders: ___Text Message ___E: Mail ___Phone ___ Do Not Call

Employer: ________________________ Occupation: ___________________________________

Referred By:-____

Name of Family Physician: _________________________________Phone #: ______________

Physician's Address:____

Date of Last Physical Examination: _____________________Height: _________ Weight: _________

Billing Information

Guarantor: ____ DOB: _______________
(Individual responsible for payment, if different from above)

Address: _________________________________City:________________ Zip Code:__________

Dental Insurance Information

If you are covered by dental insurance, please complete the following insurance information
Payment at the time of service may be requested if insurance information is incomplete.

Primary Dental Insurance

Subscriber Name: ____ DOB: ___________________

Insurance Carrier: _________________Subscriber #: ______________Group Number______________

Billing Address: ____

Employer:____

Secondary Dental Insurance

Subscriber Name: ____ DOB: ___________________

Insurance Carrier: _________________Subscriber #: ______________Group Number:______________

Billing Address: ____

Employer:____

HEALTH QUESTIONNAIRE

Please answer "YES" or "NO" to the Following Questions
Answers to the following questions are for <u>our records only</u> and will be considered confidential.

Yes..No 1. Are you in good health? ______

Yes..No 2. Has there been any change in your general health within the past year? ______

______

Yes..No 3. Are you under the care of a physician for any problem? ______

Yes..No 4. Have you ever had any serious illness or operations? ______

Yes..No 5. Do you have, or have you had any of the following: ______

- Yes..No —Rheumatic fever
- Yes..No —Mitral valve prolapse
- Yes..No —High blood pressure
- Yes..No —Stroke
- Yes..No —Heart murmur or click
- Yes..No —Heart attack or disease
- Yes..No —Chest pain or angina
- Yes..No —Artificial joint or valve
- Yes..No —Bleeding or blood disorder
- Yes..No —Venereal disease
- Yes..No —Tuberculosis
- Yes..No —Hepatitis or liver disease
- Yes..No —Asthma
- Yes..No —Diabetes
- Yes..No —Seizures
- Yes..No —Cancer
- Yes..No —Frequent headaches
- Yes..No —Thyroid condition
- Yes..No —Chronic illnesses
- Yes..No —Herpes virus (Cold Sores)
- Yes..No —AIDS or HIV+ infection
- Yes..No —Radiation or chemotherapy

Yes..No 6. Have you ever had surgery or x-ray treatment for a tumor or growth, or other condition of your mouth or face?

______

Yes..No 7. Are you now taking any drug or medicine (including aspirin) for any reason? If yes, please list: ______

______

Yes..No 8. Have you ever had abnormal bleeding from previous extractions, surgery, or when cut? ______

9. Are you allergic or sensitive to any of the following:

- Yes..No —Local anesthetics ("novocaine")
- Yes..No —Penicillin or other antibiotics
- Yes..No —Aspirin, codeine, or other drugs for pain
- Yes..No —Others (<u>please specify</u>) ______

WOMEN ONLY

Yes..No 10. Are you pregnant? ______

Date of Last Menstrual Period ______

SUMMATION

Allergies and reactions ______

______

______

Medications ______

______

______

______

______

______

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DENTAL QUESTIONNAIRE

Reason for this visit: ______________________________

Date of last dental treatment: ______________________ Date of last dental x-rays: ______________

Please Answer "YES" or "NO" to the Following Questions

Yes..No 1. Have you ever had any serious problems with previous dental treatment? ______________

Yes..No 2. Are you presently in pain? ______________

Yes..No 3. Are there any areas in your mouth you avoid or have difficulty chewing on? ______________

Yes..No 4. Have you ever been told that you grind your teeth at night? ______________

Yes..No 5. Do you experience any pain or fatigue in your jaws or face? ______________

Yes..No 6. Do you experience frequent headaches? ______________

Do any of the following stimuli bring on tooth pain?

Yes..No Cold

Yes..No Hot

Yes..No Sweet

Yes..No Biting Pressure

Yes..No Brushing

Yes..No Flossing

FOR OFFICE USE

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Yes..No 7. Have you had orthodontic therapy? ______________

Yes..No 8. Have you had your wisdom teeth removed? ______________

Yes..No 9. Do you wear dentures? ______________

Yes..No 10. Do you gag easily? ______________

Yes..No 11. Do you use a soft bristled toothbrush? ______________

FOR OFFICE USE

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Yes..No 12. Are you pleased with the appearance of your teeth? ______________

FOR OFFICE USE

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Patient Signature ______________________ Interviewer Signature ______________________