



Family Dentistry of Lowell

PATIENT INFORMATION

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential):

Date: _____

Name _____ Birthdate _____

SS# _____ - _____ - _____ Driver's License # _____ - _____ - _____

Address _____ City _____ St _____ Zip _____

Home phone _____ Work phone _____ ext _____

Cell _____ Pager _____

E-mail address _____ *(Please print very carefully)*

Employer _____ Preferred Name _____

Minor Single Married Separated Divorced Widowed

Whom may we thank for referring you?

Person to contact in case of an emergency _____ Phone _____

If Minor : Mother's Name _____

Date of Birth _____

Work phone # _____ ext _____

Employer _____

SS # _____ - _____ - _____

Father's Name _____

Date of Birth _____

Work phone # _____ ext _____

Employer _____

SS# _____ - _____ - _____

If college student, name of college _____ City _____ St _____

Full time Part time *Has student status been established with your insurance carrier?*

yes no

Insurance Information (Primary):

Name of Insured _____ Relationship to patient _____ DOB _____

SS# _____ Group # _____

Insurance Carrier _____ Employer _____

Insurance Address _____ City _____ St _____ Zip code _____

Phone # _____

Insurance Information (Secondary):

Name of Insured _____ Relationship to patient _____ DOB _____

SS# _____ Group # _____

Insurance Carrier _____ Employer _____

Insurance Address _____ City _____ St _____ Zip code _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? yes no If yes, please explain _____
 Have you ever been hospitalized or had a major operation? yes no If yes, please explain _____
 Have you ever had a serious head or neck injury? yes no If yes, please explain _____
 Are you taking any medications, pills, or drugs? yes no If yes, please explain _____
 Do you take, or have you taken Phen-Fen or Redux? yes no Vitamin supplements _____
 Are you on a special diet? yes no Do you use controlled substances? yes no
 Do you use tobacco? yes no Are you wearing contact lenses? yes no
 Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? yes no

Women: Are you pregnant/trying to get pregnant? yes no Taking oral contraceptives? yes no Nursing? yes no

Are you allergic to any of the following? Aspirin Penicillin or other antibiotics Codeine Acrylic Metal
 Latex Iodine Local Anesthetics Sedatives Barbiturates other

Do you have, or have you had, any of the following?

| | | | | | |
|---------------------------|--|---------------------------|--|----------------------------|--|
| AIDS/HIV Positive | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Thirst | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alzheimer's Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting spells/Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in Jaw Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anaphylaxis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parathyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Genital Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joint | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal Dialysis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/Failure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Pace Maker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Trouble/Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A | <input type="checkbox"/> Yes <input type="checkbox"/> No | Spina Bifida | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pains | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B or C | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/Intestinal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores/Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Limbs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives or Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Medicine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular Heartbeat | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drug Addiction | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors or Growths | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Easily Winded | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy or Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Excessive Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ | |

Name of previous Dentist and location _____ Date of last exam _____
 Do your gums bleed while brushing or flossing? _____ Are your teeth sensitive to hot or cold? _____ Frequent headaches? _____
 Are your teeth sensitive to sweet or sour foods? _____ Do you clench or grind your teeth? _____ Do you feel pain to any of your teeth? _____
 Do you bite your lips or cheeks frequently? _____ Have you ever had complications with any extractions? _____ Prolonged bleeding? _____
 Do you like your smile? _____ Have you had orthodontic treatment? _____ Do you wear partials or dentures? _____
 Do you have any sores or lumps in or near your mouth? _____ Have you had head, neck or jaw injuries? _____
 Have you ever experienced any of the following problems with your jaw: Clicking _____ Pain (joint, ear, side of face) _____ Difficulty chewing _____
 Difficulty in opening or closing _____?

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependents.

 Signature of patient (or parent/guardian if minor)

 Date