# Quincy Dental

875 Southern Artery, Quincy, MA, 02169
Tel: 617- 471- 4449

## GETTING TO KNOW YOU

Name: _____ Date: _____
First Middle Last

Address: _____
Street or P.O. Box City State Zip Code

Phone: _____
Home Work

E-mail: _____

Birthdate: _____ Social Security Number: _____
Month Day Year

Occupation: _____ Employer: _____

Whom may we thank for referring you? _____

Person to contact for emergency: _____ Phone: _____

When was your last dental visit? _____ Date of last complete X-rays: _____

Name of Previous Dentist: _____

## INSURANCE INFORMATION

Insured person's full name: _____

Work Phone: _____ Social Security Number: _____

Insurance Company: _____

Relationship to Patient: _____ Date of Birth: _____

Group or Union Name: _____

Group or Local Number: _____

## MEDICAL HISTORY

1. Are you having any dental problems at this time? ◯ Yes ◯ No
2. Do your gums bleed at any time? ◯ Yes ◯ No
3. Do you feel nervous about having dental treatment? ◯ Yes ◯ No
4. Have you ever had a bad experience in the dental office? ◯ Yes ◯ No
5. Have you been under medical care or hospitalized during the past two years? ◯ Yes ◯ No

   If yes, for what reason? _____
6. Are you allergic to any drugs or medication (itching, rash, swelling)? ◯ Yes ◯ No
7. Have you ever been made sick by penicillin, aspirin, codeine or any drugs? ◯ Yes ◯ No
8. Have you ever had any excessive bleeding requiring special treatment? ◯ Yes ◯ No
9. Women: Are you pregnant? If yes, when are you due? ◯ Yes ◯ No

   Are you taking birth control pills? ◯ Yes ◯ No
10. Check any of the following which you have had or have at the present:

| | | | |
|---|---|---|---|
| ☐ Heart Disease or Attack | ☐ Artificial Joint | ☐ Thyroid Disease | ☐ Liver Disease |
| ☐ Angina (chest pain) | ☐ Anemia | ☐ Radiation therapy | ☐ Yellow Jaundice |
| ☐ High Blood Pressure | ☐ Ulcers | ☐ Chemotherapy | ☐ Blood Transfusion |
| ☐ Heart Murmur | ☐ Shortness of Breath | ☐ Glaucoma | ☐ Diabetes |
| ☐ Rheumatic Fever | ☐ Emphysema | ☐ Arthritis | ☐ Hemophilia |
| ☐ Congenital Heart Problems | ☐ Tuberculosis (TB) | ☐ Rheumatism | ☐ Venereal Disease |
| ☐ Stroke | ☐ Asthma | ☐ Cortisone Medication | ☐ Epilepsy or Seizures |
| ☐ Artificial Heart Valve | ☐ Sinus Trouble | ☐ HIV Positive | ☐ Fainting or Dizzy Spells |
| ☐ Heart Pacemaker | ☐ Allergies or Hives | ☐ Hepatitis A (Infectious) | ☐ Psychiatric Treatment |
| ☐ Heart Surgery | ☐ Pain in the Jaw Joints | ☐ Hepatitis B (Serum) | ☐ Kidney Trouble |

11. Have you been using recreational drugs? ◯ Yes ◯ No
12. Do you ever have chest pain or shortness of breath from walking? ◯ Yes ◯ No
13. Has your physician ever said you have cancer or a tumor? ◯ Yes ◯ No
14. Are you on a special diet under a physicians care? ◯ Yes ◯ No

    If yes, have you taken Phen-Phen? ◯ Yes ◯ No
15. Please list any disease or condition not covered above. _____
16. If you smoke or drink, how much each day? _____
17. Please list all the medications you are taking at this time (including fluoride). _____

_____

19. How do you feel about the appearance of your teeth? _____
20. If you could change anything about your smile, what would you change? _____

*To the best of my knowledge, I have answered every question completely and accurately.*
*I will inform my dentist of any change in my health and/or medication.*

Patient Signature _____ Date _____

History Reviewed _____ Date _____ History Reviewed _____ Date _____

History Reviewed _____ Date _____ History Reviewed _____ Date _____