45 Walpole St,
Norwood, MA 02062

Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health and esthetics.
To help us better serve you, we ask you to fill out these forms completely. The better we communicate, the better we can care for you!

Date ___/___/___ **Please complete each question**

Patient Information

Patient's Name____
Last First Middle Preferred Name

Street Address____
Street City State Zip

Mailing Address____
Street City State Zip

Home Phone# (____)________________ Date of Birth ___/___/____ Social Security# ____-____-_____

Cell Phone # (____)___________________________ Pager # (____)________________________

Marital/Family Status ☐Married ☐Single ☐Widowed ☐Divorced ☐Child

Spouse's Name____
Last First Middle

If patient is minor, Parents' or Guardians' name_______________________________

If full time college student_______________________________________
Name of School City State

Employer_______________________ Occupation_____________________ # Yrs. Employed_____

Work Phone # (____)_______________ Ext. ______

Which telephone # is best to reach you during the day? _____________________________

Email Address____

Whom may we thank for referring you? _________________________________

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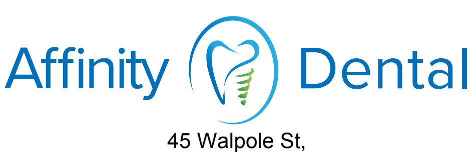

45 Walpole St,
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Emergency Information

Who should we call in case of an emergency?______________________ Phone # (____)_____________

Responsible Party Information (if different than person above)

Do you prefer to have an account separate from your spouse? ☐ Yes ☐ No, combine as family account

Name of person financially responsible for account ____
Last First Middle

Responsible party's mailing address ____
Street City State Zip

Responsible party's home phone # (____)_________________ Work phone # (____)_________________

Responsible party's social security # ____-____-____ Date of Birth ___/___/___ Relation to patient______

Responsible party's employer_________________ Occupation_______________ # Yrs employed ______

Patient Dental History

What would you like us to do for you? Check all that apply.

☐ Help me keep my teeth for life

☐ Help me improve my smile

☐ Check my mouth and give me a report

☐ I want to prevent decay and toothaches

☐ I want fresher breath

☐ I want whiter teeth

☐ Stop my gums from bleeding

☐ Get me out of pain

☐ Fix the hole in my tooth

☐ Give me some more teeth to chew with

☐ Remove my wisdom teeth

☐ Teach me how to care for my teeth

All of the requests above are possible to achieve. They will require some work on our part and yours as well. We will create a plan for you that will meet the goals you have for your mouth. It may take some time, but when we are finished you will have the satisfaction of knowing that it was done right and that you know how to care for your mouthy and protect your investment in good dental health!

Continued on back

45 Walpole St,
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Dental History

When was your last dental exam? ________________________________ Last X-rays?________________

Last Cleaning? __________________ Name of previous dentist? __________________________________

What is your main concern?

____

____

Have you had orthodontic treatment? ☐ Yes ☐ No

Have you had periodontal treatment? ☐ Yes ☐ No ......if yes, when? ____________________

Do you clench or grind you teeth? ☐ Yes ☐ No ......Daytime? _____ Night time? _______

Do you have ear pain, sore facial muscles? ☐ Yes ☐ No ......Do you awaken with headaches?____

Are you apprehensive about seeing a dentist? ☐ Yes ☐ No ......why? ___________________________

____

Have you ever had an adverse reaction to a dental anesthetic? ☐ Yes ☐ No

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HEALTH HISTORY

Name________________________________ Date of Birth ________________ Date____________________

Date of Last MEDICAL Exam____________________ What was this exam for? _____________________________

Have you been hospitalized in the past 5 years? Please circle: NO YES
If yes, reason: ____
Are you currently receiving medical care? NO YES
If yes, nature of care: ____

Please list all the names and phone numbers of the physicians who are currently providing you care: 1. _
2. ____
3. ____
4. ____

For the following questions, please circle yes or no, if you now have or have ever had the listed issues*. Your will be confidential. Please note that during your initial visit, you will be asked some questions about your response. Our team may ask additional questions concerning your health.*

Anemia or Blood Disorder	No	Yes	Mitral Valve Prolapse	No	Yes
Arthritis, Rheumatism or Other Inflammatory Disease	No	Yes	Hepatitis, Any Form	No	Yes
Asthma	No	Yes	Joint Replacement/ Artificial Joints/ Prostheses When Placed:	No	Yes
Abnormal Bleeding From a Cut	No	Yes	Kidney Disease/ Kidney Problems	No	Yes
Cancer or Tumor	No	Yes	Liver Disease (Including Jaundice)	No	Yes
Diabetes	No	Yes	Sore/ Enlarged Lymph Nodes	No	Yes
Emphysema or Other Respiratory/ Lung Illness	No	Yes	Pacemaker	No	Yes
Epilepsy	No	Yes	Psychosis	No	Yes
Fainting or Dizzy Spells	No	Yes	Previous Biopsies	No	Yes
Glaucoma	No	Yes	Radiation or Chemotherapy	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Rheumatic Fever	No	Yes
Heart Valve (Artificial) or Heart Transplant	No	Yes	Slow-Healing Mouth Sores	No	Yes
Congenital Heart Disease	No	Yes	Unintentional Weight Loss or Weight Gain	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	H.I.V. Infection/ AIDS or ARC	No	Yes
Heart Stent Date Placed:	No	Yes	Venereal Disease	No	Yes
Artificial Heart Valve Implant	No	Yes	Stomach Problems	No	Yes
Heart Murmurs	No	Yes	Psychiatric Treatment	No	Yes
Liver Problems	No	Yes	Tuberculosis	No	Yes
Recurrent Illnesses	No	Yes	Other illness/ problem not listed above	No	Yes

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Please tell us about any diseases or problems not covered in prior list/ or if you circled “Yes” to “Other illness/ problem not listed above”:

____

____

Are you taking any of these medications?

Fish Oil	No	Yes	Tagamet® (cimetidine) or Prilosec®	No	Yes
Antacids Name of Antacid:	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (verapamil)	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John’s Wart or Kava Kava	No	Yes	Biaxin® (clarithromycin)	No	Yes

Have you been treated with Bisphosonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®) for bone tumors, excessive calcium in your blood, or osteoporosis? If so, when did treatment begin and end:	No	Yes
Have you ever taken any prescription drugs such as Fen-phen/ fenfluramine/ fenfluramine combined with phentermine, dexfenfluramine (redux), or other prescription drugs for weight loss?	No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit juice extract?	No	Yes

Please list ANY medications you are currently taking and dosages:

Medication Name:	Dosage:	How often:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Please list ANY dietary or herbal supplements you are currently taking and for what purpose:

Supplement Name:	Dosage:	How often:
1.		
2.		
3.		
4.		

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Women: Is there any chance you may be pregnant? NO YES

If no, are you planning a pregnancy in the near future? NO YES

Are you a nursing mother? NO YES

Are you taking birth control pills? NO YES

Abnormal Blood Pressure? (Please circle)

Have you ever been told you have "low blood pressure?" NO YES

Have you ever received a diagnosis of "high blood pressure?" NO YES

What is your normal blood pressure? S _____ /D _____

Are you allergic or have you had a reaction to:

a. Local Anesthetics NO YES

b. Penicillin or other antibiotics ______________________________ NO YES

c. Aspirin, Ibuprofen or Tylenol® NO YES

d. Codeine, Valium® or other sedatives _______________________ NO YES

e. Latex or Metals NO YES

f. Other (Please Specifiy) ____

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: Smoke Chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes
Do you habitually use controlled substances?	No	Yes

Weight and Diet Considerations

Weight	Meals Per Day	Dietary Restrictions	Food Allergies

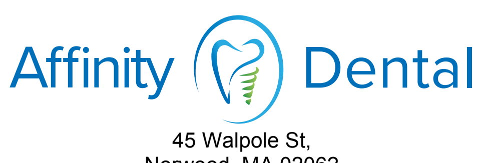
Amount of Sugar in Your Diet (circle one): None Slight Moderate High

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you. I will notify the doctor of change in my health and medication.

_______________________________ _______________________________

Patient (Print Name) Patient (Signature)

Date ______________________________



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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____
Address: ____
Telephone: ________________________ E-mail:______________________________
Patient #:________________________Social Security #:________________________

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at (781) 255-1100, or by mailing us at 45 Walpole St., Norwood, MA 02062.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:___________________________________Date: ______________________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:____

Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in the patient's chart.