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ELIZABETH RUSS FAMILY DENTAL

234 Chestnut Street
Needham, MA 02492
Tel: 781-444-0038
Fax: 781-444-3180

Date _____

Welcome to our office. Please answer all questions. This information is confidential and will help us serve you better. If at any time you have any questions regarding your treatment, your appointments, or fees, please ask.

Name _____ Date of Birth _____

Name You Wish To Be Called _____ Marital Status _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

Social Sec. # _____ Student _____ School _____

Employer _____ Address _____

Occupation _____ Work Phone _____ Ext. _____

Name of Spouse _____ Employer _____

Person Responsible for Payment _____

Address _____

Family Physician _____ Date of Last Medical Exam _____

Emergency Contact 1: Name _____ Phone _____

Emergency Contact 2: Name _____ Phone _____

Who Referred You to This Office _____

PLEASE INDICATE BELOW HOW YOU PREFER TO PAY FOR YOUR DENTAL TREATMENT

Cash _____ Personal Check _____ Dental Insurance _____ Credit Card _____

Insured Name _____ Insured Date of Birth _____

Insured Soc. Sec. # _____ Policy Number _____

Employer Providing Insurance _____

Insurance Company Name _____

Other Insurance? (if yes) _____

Insured Name _____ Insured Date of Birth _____

Insured Soc. Sec. # _____ Policy # _____

Employer Providing Insurance _____ Insurance Company Name _____

Continued on the other side. Turnover please →

Date _____

Medical History

	YES	NO
Are you in good health?	☐	☐
Under physicians care?	☐	☐
Hospitalized or serious illness?	☐	☐
Allergic to Novicaine?	☐	☐
Excess bleeding requiring special treatment?	☐	☐
Do you smoke?	☐	☐
(Women) Are you pregnant?	☐	☐
(Women) Are you nursing?	☐	☐
(Women) Are you using birth control?	☐	☐
Are you allergic to any drugs/medications?	☐	☐
If yes, list _____		
Are you currently taking any medications?	☐	☐
If yes, list _____		

	YES	NO
High Blood Pressure	☐	☐
Heart Problems	☐	☐
Rheumatic Fever	☐	☐
Fainting/Seizures	☐	☐
Asthma	☐	☐
Epilepsy/Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney/Liver Problems	☐	☐
AIDS/HIV	☐	☐
Thyroid Problem	☐	☐
Cardiac Pacemaker	☐	☐
Angina	☐	☐
Do you have any allergies?	☐	☐
If yes, list _____		

	YES	NO
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement /Implant	☐	☐
Hepatitis/Jaundice	☐	☐
Stomach Trouble/Ulcer	☐	☐
Stroke	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Respiratory Problems	☐	☐
Mitral Valve Prolapse	☐	☐

DENTAL HISTORY

What is the purpose of your visit today? _____

	YES	NO
Is your mouth comfortable?	☐	☐
Do you receive regular dental care?	☐	☐
Are you pleased with the health of your teeth?	☐	☐
Are you happy with the appearance of your teeth?	☐	☐
If not, what would you change? _____		
Would you like your teeth whitened?	☐	☐
Do you chew on both sides of your mouth?	☐	☐
Are your teeth sensitive to: (circle all that apply) **cold** **sweets** **hot** **biting pressure**?		
Do you experience frequent headaches?	☐	☐
Do you have dental anxiety?	☐	☐
If yes, what is the cause? _____		
Have you had a complete set of mouth x-rays?	☐	☐
If yes, when? _____ If yes, what office? _____		
Do you have any sores or swelling in your mouth?	☐	☐
Do you have difficulty opening or closing?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you wear a mouth guard/night guard?	☐	☐
Have you worn braces?	☐	☐
Do your gums bleed when brushing or flossing?	☐	☐
Have you been told you have periodontal disease?	☐	☐
Do you ever experience dry mouth?	☐	☐

What is the date of your last dental exam or visit? _____ Where? _____

What was the date of your last dental cleaning? _____

How often do you: Brush _____ Floss _____ Proxabrush _____ Rinse _____

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature _____ Print Name _____