Hingham Dentistry, PC

169 Lincoln Street, Suite 101
Hingham, MA 02043
(781) 740-0100

Date:

Name: _____ Date of Birth: _____ Sex: M F

Address: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

SS# _____Occupation: _____ E-mail: _____

Marital Status (please circle one): Single Married Divorced Separated Widow/Widower

Emergency Contact: _____ Number: _____Relationship: _____

Whom May We Thank For Referring You?: _____

PATIENTS DENTAL HEALTH

Why have you come in to see us today? _____

Previous Dentist/ Last Visit/ Date of last cleaning: _____

Are you nervous about seeing a dentist? Yes! No If yes, why: _____

How often do you brush? _____ Do you floss? Yes No How often: _____

(please circle Y for yes and N for no)

Y N Are you happy with your smile?

Y N Are you interested in whitening your teeth?

Y N Do you clench or grind your teeth during the day or while sleeping?

Y N Do you have any clicking, popping or discomfort in the jaw?

Y N Do your gums bleed, or feel tender or swollen?

Y N Are your teeth sensitive to cold, hot, sweets or pressure?

Y N Have you ever had orthodontic (braces) treatment?

Y N Have you ever had any periodontal (gum) treatment?

Y N Do you have sores or ulcers in your mouth?

Y N Do you have earaches or neck pains?

Y N Do you wear dentures or partials?

Initial Here _____

PATIENTS MEDICAL HEALTH

Do you or have you had any of the following? (Please circle Y for yes or N for no)

Y N Heart Disease

Y N Heart Murmur/Mitral Valve Prolapse (Circle)

Y N Stroke _____ (Date)

Y N Angina

Y N Congestive Heart Failure

Y N Congenital Heart Lesions

Y N Excessive Urination/Thirst

Y N Abnormal Blood Pressure - High or Low

Y N Anxiety

Y N Neurological Disorders _____

Y N Abnormal Bleeding Disorder

Y N Tuberculosis or Lung Disease (Circle one)

Y N Emphysema or Bronchitis (Circle one)

Y N Immune Suppressed Disorders

Y N Kidney Disease

Y N Hay Fever

Y N Fainting Spell

Y N Cancer/Chemotherapy _____ (Type)

Y N Epilepsy/Seizure

Y N Ulcers

Y N Eating Disorders

Y N History of Drug Addiction_____(Type)

Y N Liver Disease

Y N Jaundice

Y N Hepatitis Type _____

Y N Heart Attack _____ (Date)

Y N Anemia

Y N Diabetes Type _____

Y N Rheumatic Fever

Y N Infectious Mono

Y N Herpes _____(Type)

Y N Osteoporosis

Y N Arthritis or Rheumatoid Arthritis (Circle one)

Y N STD/Venereal Disease _____ (Type)

Y N Thyroid Problems

Y N Asthma

Y N Hearing Loss

Y N Tumor or Malignancy

Y N Sinus Trouble

Y N Glaucoma

Y N Radiation Treatment

Y N AIDS or HIV (Circle one or both)

Y N Malnutrition

Y N Nervous Disorders

Y N Implants/Artificial Joints: Hip Knee Other

Y N Are you taking any medications? If so, please list all:

_____

Y N Smoke/use tobacco? If yes, how much per day? _____How many years? _____

Y N I usually take antibiotics prior to dental treatment.

Initial Here _____

Y N Are you taking or scheduled to take either of the medications: alendronate (Fosamax) or risedronate (Actonel) osteoporosis or Paget's disease?

Y N Since 2001, were you treated or scheduled to begin treatment with intravenous bisphosphonate medications (Aredia or Xometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer?

If so: Date began_____

Y N Have you ever taken Fen-Phen or Redux?

Y N Have you ever had major surgery: Year: _____ Type: _____

Y N Do you have any other medical problem/medical history NOT listed on this form?

If so, what are they? _____

Are you allergic to any of the following? (please circle Y for yes or N for no)

Y N Aspirin

Y N Sulfa Drugs

Y N Penicillin

Y N Latex, Metals, Plastics

Y N Local Anesthetics (Novocain)

Y N Other Medications

Y N Ibuprofen

Y N Codeine

Other _____

If so, which one(s)? _____

If so, which one(s)? _____

WOMEN

Y N Are you taking birth control medication?

Y N Are you or could you be pregnant or nursing?

Note: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient's Signature: _____Date: _____

Doctor's Signature: _____ Date:_____

Initial Here _____