PATIENT INFORMATION

Welcome and thank you for choosing Saugus Dental! If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name (*Last, First Middle*) ____________________ Date ____________

☐ Male ☐ Female SSN ______-______-______ DOB ____/____/____

Address ____________________ Home Phone (____) ______ - ______

City ____________________ State ______ Zip Code ____________

Employer ____________________ Occupation ____________________

Address ____________________ Work Phone (____) ______ - ______

City ____________________ State ______ Zip Code ____________

Person to contact in case of emergency: Name *(Last, First)* ____________________

Relationship to Patient ____________________ Phone (____) ______ - ______

Whom may we thank for referring you ? ____________________

INSURANCE INFORMATION

Subscriber (Last, First) ____________________ Relationship to Patient ____________

Employer ____________________ DOB ____/____/____ SSN ______-______-______

Insurance Co. ____________________

Group # ____________________ Policy # ____________________

I authorize the release of information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I also hereby assign payment of insurance benefits to Saugus Dental, otherwise payable to me, for services rendered.

____ ____/____/____

Signature of patient (or parent/guardian if patient is a minor) Date

DENTAL HISTORY

Reason for today's visit ____________________

Former dentist ____________________ City/State ____________________

Date of last dental visit ____________________ Date of last dental x-rays ____________________

Please mark "Yes" or "No" to indicate if you have had any of the following.

Y	N		Y	N		Y	N	
☐	☐	Bad breath	☐	☐	Foreign objects	☐	☐	Periodontal treatment
☐	☐	Bleeding gums	☐	☐	Grinding teeth	☐	☐	Sensitivity to cold
☐	☐	Blisters on lips/mouth	☐	☐	Gums swollen/tender	☐	☐	Sensitivity to heat
☐	☐	Burning sensation on tongue	☐	☐	Jaw pain/tiredness	☐	☐	Sensitivity to sweet
☐	☐	Chew on one side of mouth	☐	☐	Lip/cheek biting	☐	☐	Sensitivity when biting
☐	☐	Cigarette/pipe/cigar smoking	☐	☐	Loose teeth/broken fillings	☐	☐	Sores/growths in mouth
☐	☐	Clicking/popping jaw	☐	☐	Mouth breathing			
☐	☐	Dry mouth	☐	☐	Mouth pain when brushing			How often do you floss? ____________
☐	☐	Fingernail biting	☐	☐	Orthodontic treatment			
☐	☐	Food collection between teeth	☐	☐	Pain around ear			How often do you brush? ____________

HEALTH HISTORY

Medical doctor's name ____

Please mark "Yes" or "No" to indicate if you have had any of the following:

Y	N		Y	N		Y	N	
☐	☐	AIDS	☐	☐	Epilepsy	☐	☐	Radiation treatment
☐	☐	Anemia	☐	☐	Fainting/dizziness	☐	☐	Respiratory disease
☐	☐	Arthritis, Rheumatism	☐	☐	Glaucoma	☐	☐	Rheumatic fever
☐	☐	Artificial heart valves	☐	☐	Headaches	☐	☐	Scarlet fever
☐	☐	Artificial joints	☐	☐	Heart murmur	☐	☐	Shortness of breath
☐	☐	Asthma	☐	☐	Hepatitis	☐	☐	Sinus trouble
☐	☐	Back problems			Type _______	☐	☐	Skin rash
☐	☐	Bleeding abnormally	☐	☐	Herpes	☐	☐	Stroke
☐	☐	Blood disease	☐	☐	High blood pressure	☐	☐	Swelling of feet/ankles
☐	☐	Cancer	☐	☐	Jaundice	☐	☐	Swollen neck glands
☐	☐	Chemotherapy	☐	☐	Kidney disease	☐	☐	Thyroid problems
☐	☐	Circulatory problems	☐	☐	Liver disease	☐	☐	Tonsillitis
☐	☐	Congenital heart lesions	☐	☐	Low blood pressure	☐	☐	Tuberculosis
☐	☐	Contact lens wearer	☐	☐	Mitral valve prolapse	☐	☐	Tumor/growth on neck/head
☐	☐	Cortisone treatments	☐	☐	Nervous problems			
☐	☐	Cough, persistent or bloody	☐	☐	Pacemaker	☐	☐	Ulcer
☐	☐	Diabetes	☐	☐	Phen-fen	☐	☐	Venereal disease
☐	☐	Emphysema	☐	☐	Psychiatric care	☐	☐	Weight loss, unexplained

Women: Are you pregnant? ☐ Yes ☐ No Due Date ________________ Are you nursing? ☐ Yes ☐ No

List medications you are currently taking:

____

____

____

ALLERGIES:

☐ Bleach products ☐ Penicillin
☐ Codeine ☐ Sulfa
☐ Latex ☐ Other ______________
☐ Local anesthetic _____________________

I have read my MEDICAL HISTORY and confirm that it adequately reflects past and present conditions.

Date	Exceptions		Patient's signature	Reviewed by
___________	____________________________________	☐ NONE	___________________	_____________________
___________	____________________________________	☐ NONE	___________________	_____________________
___________	____________________________________	☐ NONE	___________________	_____________________
___________	____________________________________	☐ NONE	___________________	_____________________
___________	____________________________________	☐ NONE	___________________	_____________________
___________	____________________________________	☐ NONE	___________________	_____________________
___________	____________________________________	☐ NONE	___________________	_____________________
___________	____________________________________	☐ NONE	___________________	_____________________