Central New England Dental Associates

PATIENT INFORMATION FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F		Today's Date:
Birth Date:	Marital status:	Email:
Address:		
Primary Phone:	Secondary Phone:	
I prefer to be contacted by email phone text		
In case of emergency please contact:		Phone:
Who may we thank for referring you?		

Who will be responsible for your account?		Relation:
Driver's License#:	Birth Date:	Phone:
Address:		
Dental Insurance?	Company:	ID# or SS#

DENTAL INFORMATION

Reason for today's appointment		
When was your last dental exam?	Bleeding gums?	Sensitive teeth?
Food caught between teeth?	If you could change anything in your Smile what would that be?	

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain:
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain:
Have you ever had a serious head or neck injury? Yes No If yes, please explain:
Do you use tobacco? Yes No if yes, how much per day?
Do you use controlled substances? Yes No
Do you need to pre-medicate? Yes No If yes, please explain:

Women only	Any possibility of pregnancy?
	Expected delivery date?
	Nursing?
	Taking birth control?

MEDICATION HISTORY

Are you now taking or have taken:

Nerve pills	☐ Yes ☐ No	Pain Killers (including Aspirin)	☐ Yes ☐ No	Stimulants	☐ Yes ☐ No
Diet pills	☐ Yes ☐ No	Muscle Relaxers	☐ Yes ☐ No	Insulin	☐ Yes ☐ No
Blood thinners	☐ Yes ☐ No	Tranquilizers.....	☐ Yes ☐ No	Antidepressants	☐ Yes ☐ No
Any bone density medications (Boniva, Fossamax, Actonel)					☐ Yes ☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Are you allergic to or had a reaction to:

Penicillin ..... ☐ Yes ☐ No	Valium or other tranquilizers ..... ☐ Yes ☐ No	Soy ..... ☐ Yes ☐ No
Latex ..... ☐ Yes ☐ No	Aspirin ..... ☐ Yes ☐ No	Codeine or other narcotics ..... ☐ Yes ☐ No
Sulfa ..... ☐ Yes ☐ No	Local Anesthetics ..... ☐ Yes ☐ No	Sulfites ..... ☐ Yes ☐ No

HEALTH HISTORY

AIDS/HIV Positive .....☐Yes ☐No	Excessive Bleeding.....☐Yes ☐No	Leukemia ..... ☐Yes ☐No
Alzheimer's Disease.....☐Yes ☐No	Kidney Problems.....☐Yes ☐No	Stroke ..... ☐Yes ☐No
Anaphylaxis.....☐Yes ☐No	Stomach/Intestinal Disease..... ☐Yes ☐No	Liver Disease ..... ☐Yes ☐No
Anemia.....☐Yes ☐No	Irregular Heartbeat.....☐Yes ☐No	Hives or Rash ..... ☐Yes ☐No
Angina.....☐Yes ☐No	Spina Bifida.....☐Yes ☐No	Heart Pace Maker ..... ☐Yes ☐No
Arthritis/Gout.....☐Yes ☐No	Shingles.....☐Yes ☐No	Sickle Cell Disease ..... ☐Yes ☐No
Artificial Heart Valve.....☐Yes ☐No	Epilepsy or Seizures.....☐Yes ☐ No	Hepatitis A ..... ☐Yes ☐No
Artificial Joint.....☐Yes ☐No	Convulsion.....☐Yes ☐No	Hepatitis C ..... ☐Yes ☐No
Asthma.....☐Yes ☐No	Frequent Diarrhea.....☐Yes ☐No	Hepatitis B.....☐Yes ☐No
Chemotherapy.....☐Yes ☐No	Radiation Treatments.....☐Yes ☐No	Congenital Heart Disorder ..... ☐Yes ☐No
Blood Disease.....☐Yes ☐No	High Blood Pressure.....☐Yes ☐No	Heart Attack.....☐Yes ☐No
Blood Transfusion.....☐Yes ☐No	Any Joint replacement .....☐Yes ☐No	Hemophilia.....☐Yes ☐No
Breathing Problem.....☐Yes ☐No	Emphysema.....☐Yes ☐No	Renal Dialysis.....☐Yes ☐No
Bruise Easily.....☐Yes ☐No	Frequent Cough.....☐Yes ☐No	Sinus Trouble.....☐Yes ☐No
Cancer.....☐Yes ☐No	Tuberculosis.....☐Yes ☐No	Tonsillitis.....☐Yes ☐No
Chest Pains.....☐Yes ☐No	Ulcers.....☐Yes ☐No	Heart Murmur.....☐Yes ☐No
Cortisone Medicine .....☐Yes ☐No	Fainting Spells/Dizziness.....☐Yes ☐No	Rheumatic Fever.....☐Yes ☐No
Diabetes.....☐Yes ☐No	Hypoglycemia.....☐Yes ☐No	Parathyroid Disease.....☐Yes ☐No
Drug Addiction.....☐Yes ☐No	Excessive Thirst.....☐Yes ☐No	Scarlet Fever.....☐Yes ☐No
Frequent Headaches.....☐Yes ☐No	Thyroid Disease.....☐Yes ☐No	Lung Disease.....☐Yes ☐No
Glaucoma.....☐Yes ☐No	Mitral Valve Prolapse.....☐Yes ☐No	Venereal Disease.....☐Yes ☐No
Hay Fever.....☐Yes ☐No	Pain in Jaw Joints.....☐Yes ☐No	Psychiatric Care.....☐Yes ☐No
Heart Attack/Failure.....☐Yes ☐No	Tumors or Growths.....☐Yes ☐No	Rheumatism.....☐Yes ☐No
Heart Trouble/Disease.....☐Yes ☐No	Yellow Jaundice.....☐Yes ☐No	Recent Weight Loss.....☐Yes ☐No
Low Blood Pressure.....☐Yes ☐No	Herpes.....☐Yes ☐No	Other .....☐Yes ☐No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Reviewed by Dr.	Date