P A R K S I D E D E N T A L C A R E

100 Boylston Street • Suite 1040 • Boston • MA • 02116
617.426.5549 phone • 617.426.1186 fax
www.flossboston.com
parksidedentalcare@yahoo.com

Patient Registration

Date:

First Name:	Middle:	Last:	
Prefers to be called by:	Date of Birth:	Age:	
Male	Female	Email:	
Home Phone:	Cell Phone:	Work Phone:	
Address:	City:	State:	Zip:
Social Security Number:	Employed:	Single:	Married:
		Divorced:	Widowed:

Employer (or School):	Occupation:		Grade:
Address	City:	State:	Zip:

Primary Insurance

Insurance Company:	Group #:	Subscriber ID:
	DOB:	SSN:
Insured's Name:	Employer:	Relationship to Patient:

Secondary Insurance

Insurance Company:	Group #:	Subscriber ID:
	DOB:	SSN:
Insured's Name:	Employer:	Relationship to Patient:

You were referred to us by:			
Emergency Contact:	Relationship	Phone #:	
Address:	City:	State:	Zip:

Consent for Treatment

1. I hereby authorize Dr. Kristin Dority &/or her designated staff to take x-rays, study models, photographs, & other diagnostic aids deemed appropriate by Dr. Dority to make a thorough diagnosis of ____ _____'s dental needs.

Patient's Name

2. Upon such diagnosis, I authorize Dr. Dority to perform all recommended treatment mutually agreed upon by me & to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives & other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to Dr. Dority's &/or designated staff 's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment & health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed & that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service, unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand that a check of my credit history may be made.

Signature:	Date:
Relationship to Patient:	

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MEDICAL HISTORY

ame:	Date of Birth:	Today's Date:

Have you been under the care of a medical doctor during the past 2 years? YES NO
If yes, for what? _____
Physician's Name: _____ Phone: _____
Address: _____
Have you taken any medications or drugs during the past 2 years? YES NO
Are you taking any medications or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines? YES NO
If yes, please list name & dosage _____
Have you ever taken any prescription drugs for weight loss, including Fen-Phen, Pondimen, or Redux? YES NO
If yes, did you have a medical exam for heart issues? YES NO
Are you aware of having an allergic or adverse reaction to any medication or substance? YES NO
If yes, please list _____
Have you been a patient in the hospital during the past 5 years? YES NO
If yes, please explain _____

Indicate which of the following you have had, or have at present by checking the box to the right.

Heart (Surgery, Disease, Attack)		Ulcers		Hepatitis A B C (circle)	
Chest Pain		Diabetes		Venereal Disease	
Congenital Heart Disease		Thyroid Problems		A.I.D.S.	
Heart Murmur		Glaucoma		H.I.V. Positive	
High Blood Pressure		Contact Lenses		Cold Sores/Fever Blisters	
Mitral Valve Prolapse		Emphysema		Blood Transfusion	
Artificial Heart Valve		Chronic Cough		Hemophilia	
Heart Pacemaker		Tuberculosis		Sickle Cell Disease	
Rheumatic Fever		Asthma		Bruise Easily	
Arthritis/Rheumatism		Hay Fever		Liver Disease	
Cortisone Medicine		Latex Sensitivity		Yellow Jaundice	
Swollen Ankles		Allergies or Hives		Neurological Disorder	
Stroke		Sinus Trouble		Epilepsy or Seizures	
Diet (Special/Restricted)		Radiation Therapy		Fainting or Dizzy Spells	
Artificial Joints/Pins/Screws		Chemotherapy		Nervous/Anxious	
Kidney Trouble		Tumors		Psychiatric/Psychological Care	

Have you had any recent surgeries? _____ YES NO
Do you use more than 2 pillows to sleep? YES NO
Have you lost or gained more than 10 pounds in the past year? YES NO
Do you have or have you had any disease, condition, or problem not listed? YES NO
If yes, please explain: _____
Women: Are you pregnant or think you may be pregnant? YES NO
If yes, how many months? _____ Nursing? _____
Do you use birth control medications? YES NO

I understand the above information is necessary to provide me with dental care in a safe & efficient manner. I have answered all the 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 such information t Parkside Dental Care. I will notify Parkside Dental Care of any changes in my health &/or medication.

Patient/Guardian Signature: _____ Date: _____

History Review	Premed Necessary YES NO
Dentist Signature:	Date:

DENTAL HISTORY

What is the reason for your visit today? _____

Date of last dental visit_____ Last dental cleaning_____ Last full mouth x-rays_____

What was done at your last dental visit? _____

Previous dentist's name: _____ Phone: _____

Address: _____ City: _____ State: _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplack, Toothpick, etc…) _____

Do you have any dental problems now? YES NO

If yes, please describe: _____

Are any of your teeth sensitive to:

		Have you ever had:	
Hot or Cold		Orthodontic Treatment	
Sweets		Oral Surgery	
Biting or Chewing		Periodontal Treatment	
Have you noticed any mouth odors or bad tastes		A serious injury to the mouth or head Please describe:	
Do you frequently get cold sores, blisters, or oral lesions			

Have you experienced:

Do your gums bleed or hurt		Clicking or popping or the jaw	
Have your parents experienced gum disease or tooth loss		Pain (joint, ear, side of face)	
Have you noticed any loose teeth or change in your bite		Difficulty opening or closing the mouth	
Does food tend to become caught in between your teeth		Difficulty in chewing on either side of the mouth	
		Headaches, neckaches, shoulder aches, sore muscles	

Do you:

Clench or grind your teeth while awake or asleep	
Bite your lips or cheeks regularly	
Hold foreign objects with your teeth	
Mouth breathe while awake or asleep	
Have tired jaws, especially in the morning	
Snore or have any other sleeping disorders	
Smoke/chew tobacco or use other tobacco products	

Are you satisfied with your teeth's appearance? YES NO

Would you like to keep all of your teeth all of your life? YES NO

Do you feel nervous about having dental treatment? YES NO

If yes, what is your biggest concern? _____

Have you ever had an upsetting dental experience? YES NO

If yes, please explain: _____

Is there anything else about having dental treatment that you would like us to know? _____

_____

_____