214 Chestnut Street – Unit 1
Needham, MA 02492
(781)444-1145

Patient Intake Form

Patient Name:________________ Date of Birth:__________ SSN:____________
Home Address:____
City State Zip Code
Phone:________________ Email:____________________
Please check: ◯ Married ◯ Single ◯ Divorced ◯ Widow Spouse or Parent (if minor):__________
Patient's Employer:________________________ Phone:____________
Spouse or Parent Employer:________________________ Phone:____________
In Case of Emergency, notify:________________________ Phone:____________
Whom May We Thank For Referring You?________________________

PRIMARY INSURANCE INFORMATION

Name of Dental Insurance Carrier:________________________ Phone:____________
Address of Dental Insurance Carrier:________________________________
City State Zip Code
Subscriber ID Number (if different from SSN):____________ Group Number:__________
Subscriber:________________ Subscriber's SSN:______________ DOB:__________
Subscriber's Employer:______________ Patient Relation to Subscriber: ◯ Self ◯ Spouse ◯ Child

SECONDARY INSURANCE INFORMATION

Name of Dental Insurance Carrier:________________________ Phone:____________
Address of Dental Insurance Carrier:________________________________
City State Zip Code
Subscriber ID Number (if different from SSN):____________ Group Number:__________
Subscriber:________________ Subscriber's SSN:______________ DOB:__________
Subscriber's Employer:______________ Patient Relation to Subscriber: ◯ Self ◯ Spouse ◯ Child

When was your last dental visit?________________ Last X-Rays?______________
Do you presently have any dental problems?________________________
Do you have pain or sensitivity when chewing?________________________
Are your teeth sensitive to hot, cold or air?________________________
Do your gums feel tender or swollen?________________________
Do your gums bleed when brushing or flossing?________________________
Do you clench or grind your teeth?________________________
Do you have headaches in the morning?________________________
Are you aware of any inflamed or unhealed areas in your mouth?________________
Are you aware of any growths or sore spots?________________________
Are you dissatisfied with the appearance of your teeth?________________
Do you want to straighten your teeth?________________________
Are there any past dental problems that we should know about?________________
Please add anything else you think the dentist should know:________________
____

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Are you in good health? ◯ Yes ◯ No Height:____________ Weight:____________

Date of last physical exam:____/____/______ Significant findings:____

Have you been hospitalized in the last 5 years? ◯ Yes ◯ No If yes, for what?________________________

Are you presently under the care of a physician? ◯ Yes ◯ No If yes, for what?______________________

Physicians Name:____ Phone:________________________

Physicians Address:____

City State Zip Code

Present Medications:____ For what? ________________________

____ For what? ________________________

____ For what? ________________________

Do you have to **Pre-Medicate** (with antibiotics) for dental work? ◯ Yes ◯ No

Do you have or have you had any of the following? (Please check)

◯ Allergy to Penicillin
◯ Allergy to Local Anesthesia (Novocain)
◯ Abnormal Blood Pressure
◯ Heart Attacks
◯ Heart Disease
◯ Pacemaker
◯ Chest Pains (Angina)
◯ Heart Murmur
◯ Artificial Heart Valves
◯ Mitral Valve Prolepses
◯ Dizziness
◯ Fainting
◯ Anorexia/Bulimia
◯ Pregnant (presently)
◯ Respiratory Problems
◯ Asthma
◯ Sinus Problems
◯ Blood Transfusion
◯ HIV
◯ Hepatitis (type:_________)
◯ Abnormal Bleeding
◯ Circulatory Problems
◯ Anemia
◯ Alcoholism
◯ Drug Addiction
◯ Frequent Headaches
◯ Mental Health Problems
◯ Sleep Apnea/Snore
◯ Muscular Sclerosis
◯ Muscular Disease
◯ Rheumatic Fever
◯ Prosthetic Hip/Joints
◯ Arthritis
◯ Cancer
◯ Radiation Treatments
◯ Diabetes
◯ Stroke
◯ Tuberculosis
◯ Ulcer
◯ Epilepsy
◯ Herpes
◯ HPV

Any other allergies or physical conditions not listed that we should be aware of:________________________

____

I certify that I have read and understand this form. My dentist is not responsible for any errors or omissions during completion of this form.

____ ________________________

Signature Date

MEDICAL HISTORY UPDATE		CHANGES IN MEDICATION	
Date	**Condition**	**Date**	**Medication**

Today's Date: / / **Revision Date: / /**

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