41 North Road
Bedford, MA 01730
339-234-5075

87 Chestnut Street
Needham, MA 02492-2514
781-444-6650

38 Pond Street, Suite 204
Franklin, MA 02038-3826
508-520-6660

CHESTNUT
DENTAL
YOUR SMILE'S IN GREAT HANDS

PATIENT INFORMATION & HEALTH HISTORY FORM

Please complete and bring to 1st visit

Reviewed by
Dr.
Date

Name _____ D.O.B. _____

Mailing Address: Street _____ Place of Birth _____

City _____ State _____ Zip _____ Tel # _____

Home Email Address: _____ Cell # _____

Billing Address: Street _____

(If different than above) City _____ State _____ Zip _____

Occupation: _____ Name of Employer _____

Street _____ Work Tel # _____

City _____ State _____ Zip _____

Work Email Address: _____

Whom may we contact in case of emergency?

Name _____ Relationship _____ Tel # _____

Street _____ Work Tel # _____

City _____ State _____ Zip _____ E-mail Address: _____

Physician _____

Street _____ Tel # _____

City _____ State _____ Zip _____

Previous Dentist _____

Street _____ Tel # _____

City _____ State _____ Zip _____

How did you find us? _____

Whom may we thank for referring you? (If applicable) _____

I hereby authorize insurance payment directly to the Chestnut Dental Associates, P.C., the dental benefits otherwise payable to me. I also authorize the completion of all agreed and necessary dental services.

Signature: _____ **Relationship:** _____ **Date:** _____

DENTAL HEALTH HISTORY

Reason(s) for seeking dental care:

- ☐ Examination
- ☐ Routine check-up
- ☐ Toothache or swelling
- ☐ Other _____
- ☐ Appearance of teeth
- ☐ Crowding of teeth
- ☐ Accident
- ☐ 2nd Opinion
- ☐ Consultation
- ☐ Orthodontic Evaluation

If you have been to a dentist previously,

When was your last visit? _____

When were your last dental xrays taken? _____

Have you ever had any unexplained swelling in your hands, feet, face or throat after trauma to the area or after dental treatment? Y N

Have you ever had a reaction to local anesthetic ("Novacaine")? Y N

If yes describe: _____

Are you missing any teeth? Y N

Have you ever had teeth extracted? Y N

Do you wear any dental prostheses/appliances? Y N

If yes describe: _____

How often do you use dental floss? Never Sometimes Weekly Daily

What kind of tooth brush do you use? Hard Medium Soft Electric- Which brand?

How often do you brush your teeth? _____ _____

How many times/day do you consume food/beverages with high sugar content? _____

Have your teeth ever been injured? Y N

When? (Age) _____

Which teeth? _____

Cause? _____

Describe any treatment _____

_____

Do you have any of the following habits?

Night grinding (bruxism) Y N

Clenching Y N

Mouth breathing Y N

Snoring Y N

Do you presently wear or have you ever worn a night guard? Y N

Have you received any dental or surgical treatment to the mouth? Y N

If yes, describe _____

MEDICAL HISTORY

Is a physician currently treating you for a specific illness? Y N

If yes, for what reason? _____

Are you currently taking any medications, including oral contraceptives or aspirin? Y N

Drug	Reason

Have you taken any unusual medications, including Fen-Phen and Reux, in the past? Y N

If yes, what and why? _____

Have you ever or are you currently taking a bisphosphonate? (Such as Fosamax) Y N

Has your physician recommended taking an antibiotic premedication prior to your dental visits? Y N

Have you had any allergic reactions to

Medications or drugs? _____ Y N

Foods or dyes? _____ Y N

Latex or other? _____ Y N

Have you ever been hospitalized? Y N

If yes, when and where? _____

Reason for hospitalization? _____

Have you had any surgery (operations)? Y N

Date(s) and Age(s)? _____

For what reason(s)? _____

Was general anesthesia used? _____

Were there any complications? _____

Do you now or have you ever used tobacco products? Y N

Do you consume alcoholic beverages? Y N

How often? _____

Do you have any history of the following ?

- ☐ Anemia
- ☐ Angioedema
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Autism
- ☐ Bleeding (prolonged)
- ☐ Brain Injury
- ☐ Cancer: Type _____
- ☐ Cardiac Transplant
- ☐ Cerebral Palsy
- ☐ Cleft Lip/Palate
- ☐ Cognitive Delays
- ☐ Congenital Heart Disease
- ☐ Diabetes
- ☐ Emotional disability
- ☐ Endocarditis
- ☐ Fainting (often)
- ☐ Gastrointestinal Disorders
- ☐ Hearing Loss: Type _____
- ☐ Heart Attack/Angina
- ☐ Heart Disease/Murmur
- ☐ Hepatitis/Liver Disease
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV Infection (AIDS)
- ☐ Jaundice
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Lyme Disease
- ☐ Nutritional Deficiency
- ☐ Orthopedic Problems
- ☐ Pins, Plates or Screws
- ☐ Rheumatic Fever
- ☐ Transfusion of Blood
- ☐ Scoliosis
- ☐ Sickle Cell Trait or Disease
- ☐ Stroke
- ☐ Syndrome: Type _____
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Other _____ Y N

Are you pregnant? Y N

Are there any elevated stresses in your home? Y N If yes what type _____

Have you ever felt threatened in your home? Y N

MEDICAL HISTORY UPDATES

(to be completed at subsequent visits)

Date | | | |

Please review the original patient information. If there are any changes in the history, please comment below. If there are no changes, please so state.

____

____

Signature ______________________________ Reviewer ________________

Date | | | |

Please review the original patient information. If there are any changes in the history, please comment below. If there are no changes, please so state.

____

____

Signature ______________________________ Reviewer ________________

Date | | | |

Please review the original patient information. If there are any changes in the history, please comment below. If there are no changes, please so state.

____

____

Signature ______________________________ Reviewer ________________

Date | | | |

Please review the original patient information. If there are any changes in the history, please comment below. If there are no changes, please so state.

____

____

Signature ______________________________ Reviewer ________________

Date | | | |

Please review the original patient information. If there are any changes in the history, please comment below. If there are no changes, please so state.

____

____

Signature ______________________________ Reviewer ________________

Date | | | |

Please review the original patient information. If there are any changes in the history, please comment below. If there are no changes, please so state.

____

____

Signature ______________________________ Reviewer ________________