

- 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

Please complete
and bring to 1st
visit

Reviewed by
Dr.
Date

**PATIENT INFORMATION
&
HEALTH HISTORY FORM**

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:

- | | | |
|------------------------------------------------|----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Examination | <input type="checkbox"/> Appearance of teeth | <input type="checkbox"/> 2nd Opinion |
| <input type="checkbox"/> Routine check-up | <input type="checkbox"/> Crowding of teeth | <input type="checkbox"/> Consultation |
| <input type="checkbox"/> Toothache or swelling | <input type="checkbox"/> Accident | <input type="checkbox"/> Orthodontic Evaluation |
| <input type="checkbox"/> Other _____ | | |

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?

If yes, for what reason? _____ Y N

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?

If yes, what and why? _____ Y N

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 ?

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

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