**RELIANCE DENTAL CARE**

***363 Great Road #205 Bedford, MA 01730***

*Welcome to our office! To assist us in serving you, please complete the following confidential form.*

*The information provided is important to your dental health.*

Patient's name First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: ❑ Male ❑ Female ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Mailing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_ If minor, parent’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can we leave messages at this number? ❑ Yes ❑ No

Whom may we thank for referring you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Phonebook ❑ Family/Friend ❑ Online (source) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency who should we contact? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Insurance Co:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group number:\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID OR SSI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Covered by spouse’s insurance? ❑ Yes ❑ No Spouse Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse's dental insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse's birthday: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID OR SSI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Health History**

Do you have or have you had any of the following?

❑ Yes ❑ No Cancer or tumor

❑ Yes ❑ No Heart ailment or angina

❑ Yes ❑ No Heart murmur, mitral valve prolapse, heart defect

❑ Yes ❑ No Rheumatic fever or rheumatic heart disease

❑ Yes ❑ No Artificial joint or valve

❑ Yes ❑ No High or low blood pressure

❑ Yes ❑ No Pacemaker

❑ Yes ❑ No Tuberculosis or other lung problems

❑ Yes ❑ No Kidney disease

❑ Yes ❑ No Hepatitis or other liver disease

❑ Yes ❑ No Alcoholism

❑ Yes ❑ No Blood transfusion

❑ Yes ❑ No Diabetes

❑ Yes ❑ No Neurologic condition

❑ Yes ❑ No Epilepsy, seizures, or fainting spells

❑ Yes ❑ No Emotional condition- Requiring Treatment

❑ Yes ❑ No Arthritis

❑ Yes ❑ No Herpes or cold sores

❑ Yes ❑ No AIDS or HIV positive

❑ Yes ❑ No Migraine headaches or frequent headaches

❑ Yes ❑ No Anemia or blood disorders

❑ Yes ❑ No Abnormal bleeding after extractions/surgery/ etc

❑ Yes ❑ No Hayfever or sinus trouble

❑ Yes ❑ No Allergies or hives

❑ Yes ❑ No Asthma

Are you allergic to, or have you reacted adversely to any of the following?

❑ Yes ❑ No Latex materials

❑ Yes ❑ No Penicillin or other antibiotics

❑ Yes ❑ No Local anesthetics ("Novocain")

❑ Yes ❑ No Codeine or other narcotics

❑ Yes ❑ No Sulfa drugs

❑ Yes ❑ No Barbiturates, sedatives, or sleeping pills

❑ Yes ❑ No Aspirin

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Women:

* May be pregnant
* Taking hormones or contraceptives ❑ Yes ❑ No
* Are you nursing? ❑ Yes ❑ No

Please List Any/ All Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of your physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you have any disease, condition, or problem not listed above? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL HISTORY**

What would you like us to do for you ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Former Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. When was your last visit a dentist (Approximately)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. When was your last cleaning (Approximately)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. X-rays taken? ❑ Yes ❑ No If yes: ❑ Full Mouth Series ❑ Bitewings ❑ Panoramic

5. What was done at your last visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Has any dental treatment been recommended to you that you have not had done? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Are you aware of any dental problems? ❑ Yes ❑ No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Please rate the present condition of your mouth. Poor: 1 2 3 4 5 6 7 8 9 10 Excellent

9. Have you ever been treated for gum disease? ❑ Yes ❑ No If yes, what was done? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**METHOD OF CONTACT**

❑ I provide consent to the Reliance Dental Care dental practice to use my Cell Phone to (choose one or both) ❑call or ❑text regarding appointments. My cell phone number is (include area code) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ I consent to the Reliance Dental Care dental practice to call using my cell phone regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time.

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can we leave messages at this number? ❑ Yes ❑ No

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is email communication okay? ❑ Yes ❑ No

Please let us know preferred contact method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(initial)

**AUTHORIZATION**

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dental team to help determine the appropriate dental treatment. I will inform the dentist of any changes to my medical status. I give permission for my insurance company to pay the dentist benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submission. I authorize the dentist to release all information necessary to secure the payment benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of Patient/Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_