



DENTAL ASSOCIATES OF WALPOLE

Reviewed by: _____ Date: _____

Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.
The better we communicate, the better we can care for you.

ABOUT YOU

Name: _____
 Last _____ First _____
 Today's Date: _____
 Email: _____
 Birthdate: ____ / ____ / ____
 Home Address: _____

 Cell: (____) _____ Can we leave a message on this phone? Yes No
 May we send you text messages? Yes No
 Home: (____) _____ Can we leave a message on this phone? Yes No
 Work: (____) _____ ext: ____ Can we leave a message on this phone? Yes No
 Where is it best to reach you? _____
 Do you want to give us permission to speak to anyone else about your treatment or bill?
 Yes No Who? _____

 Your Employer: _____
 Occupation: _____
 How did you hear about us? _____
 Family members seen here? _____
 Previous dentist: _____
 Last dental visit? _____
 In case of emergency who should we contact?

 Relationship: _____
 Cell: _____ Home: _____

DENTAL

Why have you come to the dentist today?

Are you in pain? Yes No
 Ever had gum treatment? Yes No
 Jaw problems? Yes No
 Do your gums bleed? Yes No
 Are you happy with your smile? Yes No
 Are your teeth sensitive? Yes No

MEDICAL HISTORY

Physician's name: _____
 Phone # (____) _____ Last visit? ____ / ____ / ____
 Are you currently under the care of a physician? Yes No
 If yes, please explain _____
 Do you smoke or use tobacco in any form? Yes No
 If yes, what type of tobacco? _____
 Do you take **Fossamax** or **Actonal**? Yes No
 Are you taking any prescription, over the counter, or herbal supplement drugs? Yes No
 Birth Control? Yes No
 Are you pregnant? Yes No
 Please list each one:

 Are you allergic to or have you had a reaction to any of the following?

Local anesthetic	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aspirin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Penicillin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other antibiotic	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sulfa drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Barbituates, sedative, sleeping pill	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Codeine/Narcotics	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Latex	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Food	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other		

Have you had any of the following (these may require antibiotic premedication prior to dental work)?

Artificial heart valves	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial joints (Hip/Knee)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Infective endocarditis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Damaged valves in transplanted heart	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital heart disease:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
a. Repaired (completely) in last 6 months	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Unrepaired, cyanotic CHD	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Repaired CHD with residual effects	<input type="checkbox"/> Yes	<input type="checkbox"/> No

