DENTAL ASSOCIATES OF WALPOLE

Reviewed by: _____ Date: _____

PATIENT INFORMATION

Patient's Last Name _____ First Name _____ Gender _____ Birthdate _____ Home Telephone _____

Address _____ Town _____ Zip _____ Patient's Physician _____ Phone _____

Cell Phone _____ Email _____

Marital status: ❒ Married ❒ Single ❒ Separated ❒ Divorced ❒ Widowed

Do you give permission to leave messages on phone regarding treatment: ❒ Yes ❒ No Billing? ❒ Yes ❒ No

Is it ok to send text messages and emails?: ❒ Yes ❒ No

Do you want to give permission to speak to anyone else about your treatment or bill? ❒ Yes ❒ No

Who? _____

In case of emergency, who should we contact?

_____

Relationship: _____

Cell: _____ Home: _____

Your Employer: _____

Occupation: _____

Who can we thank for referring you to our office? _____

DENTAL HISTORY

1. Do you have any concerns about your dental health? _____

   _____

2. When was your last dental visit? Where? What was done? X-Rays taken?

   _____

   _____

3. Are you in pain? If yes, please provide details. _____

   _____

4. Have you ever had any gum treatment? _____

5. How often do you have preventive care appointments? Please circle one

   Every 3 months Every 4 months Every 6 months Seldom

6. Do you ever experience any of the following? If yes, please provide details.

   Jaw problems? _____

   Bleeding Gums? _____

   Sensitivity to hot or cold? _____

7. Is there anything you would like to change about your smile?

   _____

MEDICAL HISTORY

1. Are you under the care of a physician right now for a specific illness(es)? Please explain if Yes.

   _____

2. Do you smoke or use tobacco in any form? If Yes, what type of tobacco? Vaping?

   _____

3. Do you take a bisphosphonate (ex. Actonel, Fosamax)?

   _____

4. Women: Are you pregnant? ❒ Yes ❒ No If Yes, due date? _____

   On birth control? ❒ Yes ❒ No

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MEDICAL HISTORY

5. Please list any medications that you take, prescription, over the counter or herbal supplements.

REASON	MEDICATION	DOSE	FREQUENCY

6. Are you allergic to or had a reaction to any of the following (please be specific)?
   a. **Medications or drugs?** _____
   b. **Foods?** _____
   c. **Latex?** _____
   d. **Other?** _____

7. Do you have a history of any of the following? Please **circle** any that apply. Provide details as necessary.

Blood Pressure	High	Low	Normal
Artificial Heart Valve	Yes	No	
Emphysema	Yes	No	
Asthma	Yes	No	
Lupus	Yes	No	
Tuberculosis	Yes	No	
HIV/AIDS	Yes	No	
Snoring/Sleep Apnea	Yes	No	Any Appliances? _____
Heart Attack	Yes	No	When? _____
Cardiovascular Disease	Yes	No	Type? _____
Stroke	Yes	No	When? _____
Bleeding Disorder	Yes	No	Type? _____
Kidney/Liver	Yes	No	Type? _____
Cancer/Chemotherapy/Radiation	Yes	No	Type? _____
Diabetes	Yes	No	Type I or Type II ?
Seizure Disorder	Yes	No	Last Seizure Date? _____ Seizure Trigger? _____
Substance Use Disorder	Yes	No	Type? _____
Other Health Condition	Yes	No	Details? _____

I believe that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and that Dental Associates of Walpole adheres to all HIPAA policies. It is my responsibility to inform this office of any changes in my medical status. I hereby give my permission to Dental Associates of Walpole to provide dental treatment to me which the doctor deems necessary and appropriate. This treatment may include, but is not limited to, topical and local anesthesic (injections), fillings, radiographs (x-rays), periodic exams and preventive care (cleanings). I have received a Notice of the Privacy Practices of Dental Associates of Walpole.

Signature of Patient/Legal Guardian_____ Date _____

Health History Updates (use for two years from initial date on this form):

DATE	NO CHANGE	MEDICAL CHANGES	PATIENT INITIALS	STAFF/DR INITIALS