COOLIDGE CORNER DENTAL

367 HARVARD ST BROOKLINE MA

care at the corner

PATIENT REGISTRATION AND HEALTH HISTORY

Date:_____

Patient's Name: _____

How do you wish to be addressed?

_____

Address: _____

City:_____ State:_____ Zip:_____

E-mail:_____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

Birth Date:_____

Gender Identity: _____ Pronouns: _____

Married: ___ Single :___ Divorced: ___ Widowed: ____

Social Security #:_____

Is another member of your family or relative a patient at our office?

Name(s): _____

Relationship:_____

Who can we thank for referring you to our practice?

_____

Person to contact in emergency:

Name: _____

Relationship: _____

Phone number: _____

Address: _____

TELL US A LITTLE MORE ABOUT YOURSELF

Occupation/Interests: _____

Employer: _____

Business Address: _____

City:_____ State:_____ Zip:_____

Are you a student? Yes_____ No_____

School/University:_____

Year in school:_____

YOUR SPOUSE:

Name:_____

Occupation:_____

Employer: _____

Work Phone:_____

DENTAL INSURANCE

Primary Carrier (Insurance Company):

_____

Subscriber's Name: _____

Employer/Group Name:_____

Group Number:_____

Subscriber's Date of Birth:_____

Subscriber's I.D. Number:_____

Secondary Carrier (Insurance Company):

_____

Subscriber's Name: _____

Employer/Group Name:_____

Group Number:_____

Subscriber's Date of Birth:_____

Subscriber's I.D. Number:_____

Is someone, other than yourself, financially responsible for this account? Yes____ No

**If "yes", we require that a credit card be put on file.*

Name:_____

Relationship:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone:_____

Credit Card: MC / Visa / Amex / Discover

Acct. # _____ Exp_____

FILL OUT REVERSE SIDE→

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HEALTH HISTORY

1. Have you been a patient in the hospital during the past two years? YES NO

2. Have you been under the care of a medical doctor during the past 2 years? YES NO

Physician's Name_____Tel._____

Address_____

3. Have you taken any medication or drugs during the past 2 years? YES NO

4. Are you now taking any medication, drugs or pills? If so, list: _____

_____

5. Are you allergic to any of the following?

Aspirin	Y N	Tetracycline	Y N	Penicillin	Y N	Latex	Y N
Erythromycin	Y N	Codeine	Y N	Dental Anesthetics	Y N	*Other	Y N

*Please list any other drugs you are allergic to: _____

6. Indicate which of the following you have had or have at present: Circle "Y" or "N

Heart Failure	Y N	Cortisone Medicine	Y N	Tuberculosis	Y N	Anemia	Y N
Heart Disease or Attack	Y N	Drug Addiction	Y N	Asthma	Y N	Sickle Cell Disease	Y N
Angina Pectoris	Y N	Sinus Trouble	Y N	Hay Fever	Y N	Bruise Easily	Y N
Congenital Heart Disease	Y N	Stroke	Y N	Allergies or Hives	Y N	Liver Disease	Y N
Heart Murmur	Y N	Artificial Joints	Y N	Radiation Therapy	Y N	Yellow Jaundice	Y N
High Blood Pressure	Y N	Kidney Trouble	Y N	Chemotherapy	Y N	Epilepsy or Seizures	Y N
Arteriosclerosis	Y N	Ulcers	Y N	Osteoporosis	Y N	Fainting or Dizzy Spells	Y N
Mitral Valve Prolapse	Y N	Diabetes Type 1 Type 2	N	Hepatitis A B C	N	Nervousness	Y N
Artificial Heart Valve	Y N	Thyroid Problems	Y N	Sexually Transmitted Disease		Psychiatric Treatment	Y N
Heart Pacemaker	Y N	Glaucoma	Y N	Y N		Developmentally Disabled	Y N
Heart Surgery	Y N	Cosmetic Surgery	Y N	A.I.D.S/H.I.V. Positive	Y N	Mentally Disabled	Y N
Rheumatic Fever	Y N	Emphysema	Y N	Cold Sores/Fever Blisters	Y N	Anxiety	Y N
Arthritis	Y N	Chronic Cough	Y N	Blood Transfusion	Y N	Depression	Y N
Rheumatism	Y N	Tobacco Use	Y N	Hemophilia	Y N		

7. When walking upstairs or taking a walk, do you ever have to stop due to chest pain, shortness of breath, or being very tired? YES NO

8. Do your ankles swell during the day? YES NO

9. Do you use more than 2 pillows to sleep? YES NO

10. Have you lost or gained more than 10 pounds in the past year? YES NO

11. Do you ever wake up from sleep and feel short of breath? YES NO

12. Are you on a special diet? YES NO

If yes, please specify

_____

13. Has your medical doctor ever said you have cancer or tumor? YES NO

14. Do you have difficulty breathing at night? Yes No Are you an active snorer? YES NO

15. Do you or have you had any disease, condition or problem not listed? YES NO

If so, please list _____

For Women Only: Are you pregnant? _____ If yes, what month? _____ Are you nursing? _____Taking birth control pills? _____

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DENTAL HISTORY

1. Do you have any dental problems now? YES NO
2. Do you have any teeth that are sensitive to hot or cold? YES NO
3. Do you have any teeth that are sensitive to sweets? YES NO
4. Have you ever had:
   a. Orthodontic Treatment? YES NO
   b. Oral Surgery? YES NO
   c. Periodontal Treatment? YES NO
   d. Worn a bite place or other appliance? YES NO
5. Do your gums often bleed when you brush your teeth? YES NO
6. Have you experienced any of the following:
   a. Clicking of the jaw? YES NO
   b. Pain (joint, ear, side of face)? YES NO
   c. Difficulty in opening or closing? YES NO
7. Do you clench or grind your teeth while awake or asleep? YES NO
8. Are you dissatisfied with the appearance of your teeth? YES NO

Consent:

1. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
2. I authorize the doctors, hygienists and assistants to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by my doctor to make a thorough diagnosis of my dental needs.
3. I also authorize the doctor(s) to perform all recommended treatment mutually agreed upon by me and to use the appropriate medications and therapies indicated for such treatment. I understand that there are certain risks involved in all treatments and the use of all types of medications. Furthermore, I authorize and consent that the doctor(s) choose and employ such assistance as deemed fit to provide recommended treatment.
4. Lastly, I understand that all responsibility for payment for dental services provided in this office for me or my dependents is mine. The amount not covered by insurance is due and payable at the time services are rendered unless other arrangements have been made. Anything owed by insurance over 45 days becomes my responsibility and must be paid by the due date. In the event payments are not received by the agreed upon dates, I understand that a 2% finance charge per month (24% APR) will be added to my account. My payment must be received by the due date on the statement to avoid a $30 late payment fee.

Patient Signature_____ Date:_____

Parent /Responsible Party_____ Relationship to Patient: _____