

THE CANTON DENTAL COLLABORATIVE

THE VILLAGE MALL, CANTON, MA 02021

Name of Patient _____		(If a child, name of supporting parent) _____	
Address _____	Telephone # _____	Name of Spouse _____	
City or Town _____	State _____	Zip _____	
Patient's Social Security # (If a child, supporting parent's S.S. #) _____			
Patient (or supporting parent) employer's name and address _____		Telephone # _____	
Present Position _____	How Long? _____	Spouses Employer _____	How Long? _____
Name of Primary Dental Insurance Co. _____	Policy # _____	Name of Policyholder _____	
Name of Secondary Dental Insurance Co. (If applicable) _____		Name of Policyholder _____	
How did you hear about us? _____			
Are any other family members patients of our office? _____		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Patients with dental insurance should complete the following for our records:

DENTAL INSURANCE RECORD

<p align="center">ASSIGNMENT OF BENEFITS:</p> <p>I authorize payment of dental benefits to the named provider for professional services rendered.</p> <p>Signed (Subscriber) _____ Date _____</p>	<p align="center">RELEASE OF INFORMATION:</p> <p>I authorize the release of any dental information necessary to process this claim.</p> <p>Signed (Patient, or parent if minor) _____ Date _____</p>
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It is important that we know about your dental and medical history. Many things have a direct bearing on your dental health. Information given is strictly confidential and will not be released to anyone without your written permission.

HEALTH HISTORY

Birthdate _____ Age _____

Why are you now seeking dental treatment? _____

Please answer each question. Check yes or no. If in doubt, leave blank.

		YES	NO
1. Are you in good health now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you now under the care of a physician?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If so, what is the condition being treated? _____			
3. Have you ever been hospitalized or had a serious illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, explain _____			
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. (Women) Are you pregnant? If so, give due date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you use tobacco in any form? If yes, how much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. Have you ever had any serious trouble associated with previous dental treatment? _____
13. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____
14. Date of last dental visit _____
15. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____
If so, when? _____
16. Do you have or have you ever had any of the following?

MOUTH	YES	NO
Bleeding, sore gums	<input type="checkbox"/>	<input type="checkbox"/>
Unpleasant taste/bad breath	<input type="checkbox"/>	<input type="checkbox"/>
Burning tongue/lips	<input type="checkbox"/>	<input type="checkbox"/>
Frequent blisters, lips/mouth	<input type="checkbox"/>	<input type="checkbox"/>
Swelling/lumps in mouth	<input type="checkbox"/>	<input type="checkbox"/>
Orthos treatments (braces)	<input type="checkbox"/>	<input type="checkbox"/>
Biting cheeks/lips	<input type="checkbox"/>	<input type="checkbox"/>
Clicking/popping jaw	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty opening or closing jaw....	<input type="checkbox"/>	<input type="checkbox"/>

TEETH	YES	NO
Loose teeth	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to hot	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to cold.....	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to sweets	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to biting.....	<input type="checkbox"/>	<input type="checkbox"/>
Food impaction	<input type="checkbox"/>	<input type="checkbox"/>
Clenching/grinding	<input type="checkbox"/>	<input type="checkbox"/>
Shifting of teeth	<input type="checkbox"/>	<input type="checkbox"/>
Change in bite	<input type="checkbox"/>	<input type="checkbox"/>

ORAL HYGIENE

Do you use the following?

Brush	<input type="checkbox"/>	<input type="checkbox"/>
Dental floss.....	<input type="checkbox"/>	<input type="checkbox"/>
Fluoride rinse	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

How often do you brush _____

Brush is: Soft Medium Hard

To the best of my knowledge, all of the proceeding answers are true and correct.

If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of patient _____

Parent, or Guardian _____ Date _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Calculus: Slight _____ Moderate _____ Excessive _____ Oral cancer exam _____															
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

CLINICAL DATA

General Condition of Teeth _____

Plaque _____ Stains _____ Abrasions _____

Condition of Present Restorations _____

Overhangs _____ Contact Points _____

Inflammation of Gingival Tissue: Slight _____ Moderate _____ Severe _____

Color _____ Recession _____ Pockets _____

Condition of the Floor of Mouth _____

Palate: Hard _____ Soft _____ Cheeks _____ Lips _____

Frenum _____ Tongue _____ Ridges _____

Presence of Exudate _____ Areas of Food Retention _____ Saliva _____

TMJ _____ Neck _____ Occlusion _____

Results of X-ray: Bone _____ Root Tips _____ Impactions _____

Supernumerary _____ Abscesses _____

a	b	c	d	e	f	g	h	i	j
i	s	r	q	p	o	n	m	l	k

7. Do you have or have you ever had any of the following?

	YES	NO		YES	NO
GENERAL			HEART/BLOOD VESSELS		
Tire easily, weakness	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Marked weight change	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain discomfort	<input type="checkbox"/>	<input type="checkbox"/>
Persistent fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack trouble	<input type="checkbox"/>	<input type="checkbox"/>
EYES			Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Visual change	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
EARS			Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>
ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>
NOSE			Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Other		
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>			
THROAT			BONE/MUSCLES		
Soreness/hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
NERVOUS SYSTEM			Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	DIGESTIVE SYSTEM		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>	Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>			
RESPIRATORY			URINARY		
Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/hayfever	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD		
Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
Sputum production (phlegm)	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Cough up bloody sputum	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing while lying down	<input type="checkbox"/>	<input type="checkbox"/>	OTHER		
ENDOCRINE			Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or growths	<input type="checkbox"/>	<input type="checkbox"/>
Family history of diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid condition/goite.....	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Other					

8. Are you ALLERGIC or have you ever experienced any reaction to the following?

Local anesthetics (e.g. novocaine).....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin or codeine	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates/sedatives/sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin/other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Other allergies		

9. Are you taking any of the following?

Antibiotics/sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>
Blood thinners	<input type="checkbox"/>	<input type="checkbox"/>	Insulin/other diabetes drugs	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure medication	<input type="checkbox"/>	<input type="checkbox"/>	Digitalis/other heart medicines.....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid medicine	<input type="checkbox"/>	<input type="checkbox"/>	Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone/steroids	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamines/allergy drugs/cold remedies	<input type="checkbox"/>	<input type="checkbox"/>	Other medication		

If yes to any of the above, list name of medication and dosage below:

1. _____

2. _____

3. _____

4. _____

10. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain _____

11. Physician's Name _____ Phone _____