PATIENT INFORMATION AND HEALTH HISTORY

PATIENT INFORMATION

Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____
Home Phone: (___)_____-_____ Cell: (___)_____-_____ Work: (___)_____-_____
Person responsible for this account: _____ Patient's SS#: _____
Address: _____ City: _____ State: _____
Employed by: _____
Business Address: _____ City: _____ State: _____
Dental Insurance: _____ Referred By: _____

DENTAL HISTORY

Date of last exam: ___/___/____ Date of last dental x-rays: ___/___/____
Any previous major dental treatment: __Yes __No When/What: _____
_____
Do your gums bleed when you brush or floss? ..... __Yes __No
Are your teeth sensitive to cold, hot, sweets or pressure? ... __Yes __No
Does food or floss catch between your teeth? ..... __Yes __No
Is your mouth dry? ..... __Yes __No
Do you clench or grind? ..... __Yes __No
Have you had periodontal (gum) treatments? ..... __Yes __No
Have you had orthodontic (braces) treatment? ..... __Yes __No
Do you have pain around your ear? ..... __Yes __No
Do you have bad breath? ..... __Yes __No
Are you a mouth breather? ..... __Yes __No
Do you have clicking, popping or discomfort in the jaw? ... __Yes __No
Do you have sores or ulcers in your mouth? ..... __Yes __No
Do you wear dentures or partials? ..... __Yes __No
Have you ever had a serious injury to your head or mouth? __Yes __No
What is the reason for your dental visit today? _____

MEDICAL HISTORY

Physician's Name: _____ Last date of exam: _____ Age:_____
Joint Replacement. Have you had an orthopedic total joint (Hip, knee, elbow, finger) replacement?__Yes__No
If yes: Date: ___/___/____ What: _____Any complications? _____
Allergies-Are you allergic or have you had a reaction to: If yes please specify
Local anesthetics_____ __Yes __No
Aspirin _____ __Yes __No
Penicillin or other antibiotics _____ __Yes __No
Other _____

DO YOU HAVE OR HAVE YOU USED ANY OF THE FOLLOWING:

☐Heart Ailments	☐High Blood Pressure	☐Neurological Problems	☐Radiation Treatments
☐Arthritis	☐Fatigue Syndrome	☐Asthma	☐Diabetes
☐Kidney Problems	☐Malignancies	☐Rheumatic Fever	☐Sinus Problems
☐Stroke	☐Thyroid	☐Eye Disorders	☐Tonsillitis
☐Tuberculosis	☐Ulcer or Colitis	☐Hay Fever/Allergies	☐Psychiatric Care
☐Immune Disorders (AIDS,HIV,ARC)		☐Liver Problems or Hepatitis	☐Anemia/Blood Problems
☐Pregnant How many weeks ?_____		☐Alcohol	☐Tobacco

☐Controlled Substances(drugs)/Steroids What?_____
☐Other _____

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointments without a 24-hour notice. Once an appointment is made, please remember this time has been reserved for you. INSURANCE: To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare forms and reports to help you obtain your benefits from insurance companies, upon receipt of full or partial payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

Patient/Guardian Signature: _____ **Date:** _____

Medication List	Dosage	Reason

Marilyn Rivero, D.M.D.
235 Walnut Street
Framingham, MA 01702

Regarding Insurance

Dear Patient,

As a service to you, insurance forms will be prepared and forwarded to your insurance carrier. We are happy to submit prior approvals to the insurance company so that you will know what will be covered. Any services not covered will be the patients' responsibility. Insurance coverage may vary according to the type of dental benefit package provided and negotiated by your employer. We do not know every negotiated policy between the employee and their employer. It is your responsibility to provide the name of your insurance company, the employer's name and address as well as the group number and personal policy number. Your human resources department should have a brochure that explains all the dental benefits that you are entitled to.

*Signature*_____

*Date*_____

Acknowledgement of Receipt of Notice of Privacy Practices

_____

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

I hereby give my permission to discuss all aspects of my dental treatment to the individuals listed below:

_____ Mother

_____ Father

_____ Husband

_____ Wife

_____ Other (Please Specify) _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

_____

_____