PATIENT INFORMATION

Welcome and thank you for choosing Saugus Dental! If you have any questions, please do not hesitate to ask for assistance. We will be happy to help.

Name (Last, First Middle) _____ Date _____

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss SSN _____ - _____ - _____ DOB _____ / _____ / _____

Address _____ Home Phone (_____) _____ - _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Address _____ Work Phone (_____) _____ - _____

City _____ State _____ Zip _____

COMMUNICATION: Cell phone/Texting (_____) _____ - _____ Email _____

RESPONSIBLE PARTY:

Who is responsible for this account? _____ Relationship to patient _____

I understand that I am financially responsible for all charges relating to materials and services rendered at Saugus Dental.

✘ _____ _____

Signature of patient (or parent/guardian if patient is a minor) Date

PERSON TO CONTACT IN CASE OF EMERGENCY: (_____) _____ - _____

Name (Last, First) _____ Relationship to patient _____

Whom many we thank for referring you? _____

PHARMACY & MEDICATIONS

Pharmacy _____

Address _____

_____

Phone (_____) _____ - _____

Are you taking **ASPIRIN** or **BLOOD THINNER**? **Y N**

Are you required to be **PREMEDICATED** prior to dental work? **Y N**

List all **MEDICATIONS** that you are currently taking:

_____

_____

_____

_____

_____

DENTAL HISTORY

Reason for today's visit _____

Former dentist _____ City/State _____

Date of last dental visit _____ Date of last dental x-rays _____

Please mark "**Yes**" or "**No**" to indicate if you have or had any of the following:

Y	N		Y	N		Y	N	
☐	☐	Bad breath	☐	☐	Foreign objects	☐	☐	Periodontal treatment
☐	☐	Bleeding gums	☐	☐	Grinding teeth	☐	☐	Sensitivity to cold
☐	☐	Blisters on lips/mouth	☐	☐	Gums swollen/tender	☐	☐	Sensitivity to heat
☐	☐	Burning sensations on tongue	☐	☐	Jaw pain/tiredness	☐	☐	Sensitivity to sweet
☐	☐	Chew on one side of mouth	☐	☐	Lip/cheek biting	☐	☐	Sensitivity when biting
☐	☐	Cigarette/pipe/cigar smoking	☐	☐	Loose teeth/broken fillings	☐	☐	Sores/growths in mouth
☐	☐	Clicking/popping jaw	☐	☐	Mouth breathing			
☐	☐	Dry mouth	☐	☐	Mouth pain when brushing			
☐	☐	Fingernail biting	☐	☐	Orthodontic treatment			
☐	☐	Food collection between teeth	☐	☐	Pain around ear			

How often do you floss? _____

How often do you brush? _____

CONTINUE ON OTHER SIDE

HEALTH HISTORY

Medical doctor's name: _____

Please mark "**Yes**" or "**No**" to indicate if you have or had any of the following:

Y	N		Y	N		Y	N	
☐	☐	AIDS/HIV	☐	☐	Epilepsy	☐	☐	Respiratory disease
☐	☐	Anemia	☐	☐	Fainting/dizziness	☐	☐	Rheumatic fever
☐	☐	Artificial heart valves	☐	☐	Glaucoma	☐	☐	Rheumatoid arthritis
☐	☐	Artificial joints	☐	☐	Headaches	☐	☐	Scarlet fever
☐	☐	Asthma	☐	☐	Heart murmur	☐	☐	Shortness of breath
☐	☐	Autoimmune disease	☐	☐	Hepatitis	☐	☐	Sinus trouble
		Type _____			Type _____	☐	☐	Skin rash
☐	☐	Back problems	☐	☐	Herpes	☐	☐	Stroke
☐	☐	Bleeding abnormally	☐	☐	High blood pressure	☐	☐	Swelling of feet/ankles
☐	☐	Blood disease	☐	☐	Jaundice	☐	☐	Swollen neck glands
☐	☐	Cancer	☐	☐	Kidney disease	☐	☐	Thyroid problems
☐	☐	Chemotherapy	☐	☐	Liver disease	☐	☐	Tonsillitis
☐	☐	Circulatory problems	☐	☐	Low blood pressure	☐	☐	Tuberculosis
☐	☐	Congenital heart lesions	☐	☐	Mitral valve prolapse	☐	☐	Tumor/growth on neck/head
☐	☐	Contact lens wearer	☐	☐	Nervous problems			
☐	☐	Cortisone treatments	☐	☐	Osteoporosis	☐	☐	Ulcer
☐	☐	Cough, persistent/bloody	☐	☐	Pacemaker/defibrillator	☐	☐	Venereal disease
☐	☐	Diabetes	☐	☐	Psychiatric care	☐	☐	Weight loss, unexplained
☐	☐	Emphysema	☐	☐	Radiation treatment			

WOMEN: Are you pregnant? ☐ Yes ☐ No

Due date _____

Are you nursing? ☐ Yes ☐ No

ALLERGIES:

☐ Bleach ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Latex ☐ Other

☐ Local anesthetic _____

Please list your past **SURGERIES**:

Year	Type of surgeries:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I have reviewed my health history and confirm that it adequately reflects past and present conditions.

_____ ✘_____ _____

Date — Signature of patient (or parent/guardian if patient is minor) — Reviewed by

Date	Changes to health history	Patient's signature	Reviewed by
_____	☐ NONE _____	_____	_____
_____	☐ NONE _____	_____	_____
_____	☐ NONE _____	_____	_____
_____	☐ NONE _____	_____	_____
_____	☐ NONE _____	_____	_____
_____	☐ NONE _____	_____	_____
_____	☐ NONE _____	_____	_____