Lydia R. Legg, MSD, DDS, PLLC
41 West Street, Fl. 3, Boston, MA 02111
O 617.909.6011
F 855.491.3661
info@bostonmaxillofacialprosthetics.com

BOSTON MAXILLOFACIAL PROSTHETICS

NEW PATIENT FORM

Patient name: _____

Pronouns: _____

Date of birth: _____

Social Security Number: _____

Address: _____

Email Address: _____

Best contact phone: _____ Cell

How would you like to be addressed? _____

Retired: Yes ☐ No ☐ When: _____

Occupation:_____

Spouse/Partner/Caregiver:_____

Spouse/Partner/Caregiver Phone Number: _____

Preferred Pharmacy and Phone Number:

Referred by:

Referred for:

_____

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What is your chief complaint? How can we help you?

_____

_____

_____

_____

_____

Existing Prosthesis: Yes ☐ No ☐ Type _____

Dental Implants: Yes ☐ No ☐

If **yes**, can you please have your surgeon send us the implant information at:

info@bostonmaxillofacialprosthetics.com ?

History of Radiation Therapy: Yes ☐ No ☐

Where:_____

Dates: _____

History of Chemotherapy: Yes ☐ No ☐

History of Stem Cell/Bone Marrow Transplant? Yes ☐ No ☐ Date: _____

History of bisphosphonates and/or anti-resorptives such as: denosamub (Xgeva, Prolia), Zometa, etc.?

Yes ☐ No ☐

If **yes**, where did you receive your injections? _____

Do you have any recent CT scans of the head and neck region? Yes ☐ No ☐

Date of last CT scan? _____

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List of Current Medications:

****USE BACK OF PAPER IF NECESSARY**

Medication Name	Dosage	How often do you take this?

CARE TEAM

Primary Care Physician:

Phone:

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Location/Address:

Medical Oncologist:

Phone:

Location/Address:

Head and Neck Surgeon:

Phone:

Location/Address:

Radiation Oncologist:

Phone:

Location/Address:

Speech Pathologist:

Phone:

Location/Address:

Oral Surgeon:

Phone:

Location/Address:

Physical Therapist:

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Phone:

Location/Address:

Local Dentist:

Phone:

Location/Address:

Oral Medicine:

Phone:

Location/Address:

Plastic Surgeon:

Phone:

Location/Address:

X-RAYS

Do you have any current dental X-rays, such as a panoramic and/or periapical films? Yes ☐ No ☐

If **no,** could you have a panoramic x-ray taken at your local dentist, and emailed to:

info@bostonmaxillofacialprosthetics.com ?

If **yes**, can you please have your local dentist email them to: info@bostonmaxillofacialprosthetics.com

prior to your consultation with Dr. Legg?

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BOSTON MAXILLOFACIAL PROSTHETICS

How do you like to communicate information regarding your care?

Phone ☐ Email ☐

Is there anything further that you would like to mention regarding your history and goals of treatment, that were not already mentioned?

_____

_____

_____

_____

_____

_____