Middleton FAMILY DENTAL

224 S. Main St.
Middleton, MA 01949
978-616-9633
www.MiddletonFamilyDental.com

Welcome to Middleton Family Dental! Please fill out this form as completely as possible. We want to make sure that we are well informed about your history and any other factor that might affect your dental health and treatment

PERSONAL

Name _____ ☐ Married ☐ Single ☐ Minor ☐ Male ☐ Female
Last First M

Birth Date _____ SS# _____

Home Address _____
Street Apt# City State Zip

Employer _____ Occupation _____

Home# _____ Preferred Contact ☐ Home ☐ Cell ☐ Work ☐ Email

Cell# _____ Best Time to call _____

Work# _____ Ext _____ Email _____

How did you hear about us? _____

PERSON RESPONSIBLE FOR ACCOUNT (IF OTHER THAN YOURSELF)

Name _____ Relationship _____

Birth Date _____ SS#: _____

Home# _____ Work# _____

Home Address (if different) _____

INSURANCE – PRIMARY

Patient relationship to subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name _____

Subscriber ID # _____

Insurance Company _____

Insurance Phone # _____

INSURANCE – SECONDARY

Patient relationship to subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name _____

Subscriber ID # _____

Insurance Company _____

Insurance Phone # _____

EMERGENCY CONTACT

(Outside of Immediate Family/Household)

Name _____ Relationship _____

Telephone _____

METHODS OF PAYMENT

Patients will be expected to pay for services when treatment is rendered.
Visa/Mastercard/Amex/Discover/Checks are accepted

☐ I wish to discuss interest free financing with Care Credit

ASSIGNMENT AND RELEASE

- I authorize the dental office to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.
- I authorize and request my insurance company to pay directly to the dental office
- I understand that I am ultimately responsible for all costs of dental treatment.

Patient/Guardian Signature _____ Date _____

CONSENT

- I authorize the dentist to administer medications and perform diagnostic and therapeutic procedures as may be necessary for proper dental care.

Patient/Guardian Signature _____ Date _____

☐ Adult Patient ☐ Father ☐ Mother ☐ Guardian

Doctor Signature _____ Date _____

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MEDICAL HISTORY

Name of Physician_____ City/State_____

Have you ever been hospitalized or had an operation? Describe_____

_____

Tobacco use? What kind and how much? _____

Unusual reaction to dental injections? _____

Women (Please check): ☐Pregnant/trying to get pregnant ☐Nursing ☐Taking oral contraceptives

List all the medications or drugs you are now taking:
☐NONE
_____
_____
_____
_____

Check medications or drugs you are allergic to:
☐NONE
☐Aspirin
☐Codeine
☐Erythromycin
☐Latex Rubber
☐Local Anesthetics
☐Metals
☐Penicillin/Amoxicillin
☐Sulfa Drugs
☐Other:_____

Check any medical conditions you may have: ☐None

☐**Heart/Cardiovascular Problems**
- ☐Angina
- ☐Artificial Valves
- ☐Congenital Heart Disease
- ☐Heart Attack/Stroke
- ☐Heart Murmur
- ☐High Blood Pressure
- ☐Low Blood Pressure
- ☐Mitral Valve Prolapse
- ☐Pacemaker/Defibrillator
- ☐Rheumatic Heart Disease
- ☐Rheumatic/Scarlet Fever

☐**Kidney/Bladder Problems**
☐**Liver Trouble/Hepatitis/Jaundice**

☐**Blood Problems**
- ☐AIDS/HIV
- ☐Anemia
- ☐Blood Clotting Problems
- ☐Blood Transfusion

☐**Bone or Joint Problems**
- ☐Arthritis
- ☐Artificial Joints

☐**Lung/Allergy Problems**
- ☐Asthma
- ☐Difficulty Breathing
- ☐Emphysema/Tuberculosis
- ☐Sinus Trouble

☐**Cancer**
- ☐Leukemia
- ☐Chemotherapy
- ☐Radiation Treatment

☐**Diabetes**
☐**Epilepsy/Convulsions**
☐**Frequent Headaches**
☐**Glaucoma**
☐**Herpes or other STD**
☐**Mental Health Problems**
☐**Snoring/Sleep apnea**
☐**Stomach/Intestinal Disease**
☐**Thyroid Problems**

Do you have any disease, condition, or problem not listed previously? If so, please describe_____

_____

DENTAL HISTORY

Reason for today's visit_____ Are you in pain? ☐Yes ☐No

Do you have any other Dental problems? _____

Name of former Dentist_____ City/State_____

Date of last visit_____

Have you ever been told that you require antibiotics before dental treatment? ☐Yes ☐No

What are your concerns? (Check as many as possible):
☐Pain Avoidance
☐Appearance
☐Losing teeth
☐Gum/Periodontal Disease
☐Cavities
☐Oral Cancer
☐Wasting/Exceeding Dental Insurance Limits
☐Your General Health
☐Routine Checkup
☐Cleaning
☐Dry Mouth
☐Other_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Patient/Guardian Signature_____ Date_____
☐Adult Patient ☐Father ☐Mother ☐Guardian

Doctor Signature _____ Date_____