



Faneuil Hall Dental Associates

Date: _____

Mr. Ms. _____
Mrs. Miss. _____ Birthdate ____/____/____ Soc. Sec. No. ____/____/____

Last Name First Name Middle

Home Address: _____ City: _____ Zip: _____

Name you like to be called _____ Home Ph: (____) _____ Bus. Ph.: (____) _____

Fax (____) _____ Pager (____) _____ Cell Phone (____) _____ E-MAIL: _____

Employer & Address _____ Occupation: _____ City: _____

Person Financially Responsible (if other than self): _____ Relationship to you: _____

Do you have dental insurance we may assist you with? _____ Ins Co. Name: _____

Address: _____ Phone #: _____ Group #: _____ Subscriber #: _____

Whom may we thank for referring you to us? _____

Spouse Name: _____ Employer: _____

Person to notify in an emergency, not living in your household Name: _____ Phone # (____) _____

Method of payment (circle) Cash Insurance Check MC/VISA

Unless specific arrangements have been made, payment is due when services are rendered.

Medical / Dental History

Medical Physician: _____ Address: _____ Phone No.: _____

Date of your last Physical examination _____

Are you in good health? _____ If no, explain _____

Do you have an existing illness? _____ If yes, explain _____

Have you been hospitalized in the past two years? _____ If yes, explain _____

Do you bleed excessively when cut? _____ Do you smoke? _____ If yes, how much? _____

Are you on any medication, pills or drugs? _____ If so, please list _____

Do you now have, or have you had any of the following: _____ If yes describe under remarks.

	Yes	No		Yes	No	
1. HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	13. LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	
2. HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	14. KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	
3. BLOOD DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	15. HEPATITIS Please Circle Type A B C	<input type="checkbox"/>	<input type="checkbox"/>	
4. RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	16. ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	
5. HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	17. TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	
6. DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	18. AIDS, HIV	<input type="checkbox"/>	<input type="checkbox"/>	
7. STROKE	<input type="checkbox"/>	<input type="checkbox"/>	19. ALLERGY TO (a) PENICILLIN	<input type="checkbox"/>	<input type="checkbox"/>	
8. EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>	20. (b) OTHER ANTIBIOTICS	<input type="checkbox"/>	<input type="checkbox"/>	Which _____
9. ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	21. (c) LOCAL ANESTHETICS	<input type="checkbox"/>	<input type="checkbox"/>	
10. TUMOR HISTORY	<input type="checkbox"/>	<input type="checkbox"/>	22. (d) OTHER	<input type="checkbox"/>	<input type="checkbox"/>	
11. VD	<input type="checkbox"/>	<input type="checkbox"/>	23. ARE YOU PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>	No. Wks _____
12. RADIATION TREATMENT	<input type="checkbox"/>	<input type="checkbox"/>				

Remarks

Do you have any present dental complaints? _____ please describe: _____

When were your last dental X-ray taken? _____ Where? _____

When was your last cleaning or dental treatment? _____

If 10 was perfect dental health and 1 was total neglect, where would you place yourself? _____

Have you ever had any serious trouble associated with a dental treatment? _____

Is there anything about your previous dental treatment that you'd like to tell us? (positive or negative) _____

Have you ever been instructed in the prevention of decay and care for your gums? _____

What kind of music makes you feel most at ease? _____

Would you like to listen to Sony Walkman during your visit? _____ yes _____ no _____ maybe _____

Is there anything we can do to make your visit more comfortable? _____

Reason for transferring your care to our office: _____

I consent to whatever Dental Procedures and anesthetics are necessary for treatment of the above named patient. I also agree to assume full Financial Responsibility for all treatment rendered.

Signature _____ Date _____