

KRAFT, SCHROTT & ASSOCIATES

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www.boston-dentist.com

Today's Date: _____ E-mail Address: _____
Name: _____ Preferred Name: _____ Male Female
Last First Mi Mr Mrs Ms Dr
Birthdate: ___/___/___ Age: _____ Social Security#: _____ Single Married Divorced Widowed Separated
Home Address: _____
Street City State Zip
Home Phone #: (____) _____ Cell #: (____) _____ Work Phone#: (____) _____ Ext: _____
Employer: _____ Occupation: _____
Employer's Address: _____
Street/PO Box City State Zip

Emergency Contact

His / Her Name: _____ Relation: _____ Work Phone#: (____) _____ Home Phone #: (____) _____
Address: _____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone#: (____) _____ Social Security #: _____
Employer: _____ Work Phone#: (____) _____ Ext: _____ Drivers License #: _____
Billing Address: _____
Street City State Zip

SPOUSE INFORMATION

His / Her Name: _____ Birthdate: ___/___/___ Social Security #: (____) _____
Employer: _____ Work Phone#: (____) _____ Ext: _____ Drivers License #: _____

INSURANCE INFORMATION

Primary Insurance Orthodontic Coverage? Yes No TMJ Coverage? Yes No
Insurance Co. Name: _____ Phone #: (____) _____ Group # (Plan, Local or Policy #): _____
Insurance Co. Address: _____
Street/PO Box City State Zip
Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____
Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Why have you come to the dentist today? _____

Are you currently in pain? Yes No

Have you experienced problems associated with any previous dental work? Yes No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)? Yes No

Do you clench or grind your teeth? _____

Your current dental health is Good Fair Poor

Do you floss daily? Yes No Brush Daily? Yes No

Type of bristles on your toothbrush? Hard Medium Soft

Do your gums ever bleed? Yes No

Have you ever had periodontal disease? Yes No

Do you have mobility in your teeth? Yes No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you still have wisdom teeth? Yes No

Date of last dental visit: _____ Frequency _____

Are you happy with the way your smile looks? Yes No

Whiter Teeth? Yes No Straighter Teeth? Yes No

If not, what would you change? _____

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Address: _____
Street City State Zip

Phone #: (____) _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry/Metals	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other

Please list additional drugs/materials that cause allergic reactions: _____

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Unsure Yes No

Week #: _____ Are you nursing? Yes No

Are you taking any of the following?

Y N Acetaminophen	Y N Blood Thinners	Y N Insulin/Diabetes Drugs	Y N Thyroid Medicine
Y N Antibiotics	Y N Blood Pressure Medication	Y N Nitroglycerin	Y N Tranquilizers
Y N Antihistamines	Y N Cold Remedies	Y N Recreational Drugs	Have you ever taken Phen-Fen? Also known as Redux or Pondimin. <input type="checkbox"/> Yes <input type="checkbox"/> No
Y N Aspirin	Y N Digitalis/Heart Medication	Y N Steroids/Cortisone	

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? Yes No If yes, please list each one: _____

Have you ever been told to pre-med for dental appointments by your physician? Yes No

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Headaches	Y N Liver Disease	Y N Shingles
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Heart Attack	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Murmur	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Surgery	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Hemophilia	Y N Pacemaker	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hepatitis	Y N Persistent Cough	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Herpes	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Fainting Spells	Y N High Blood Pressure	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Cancer	Y N Fever Blisters	Y N HIV+/AIDS	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Glaucoma	Y N Hospitalized for Any Reason	Y N Scarlet Fever	Y N Venereal Disease
Y N Chicken Pox	Y N Hay Fever	Y N Kidney Problems	Y N Seizures	

Please list any serious medical condition(s) that you have experienced: _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be _____.

Signature _____

Date _____

PAYMENT IS DUE AT TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature _____

Date _____

Whom may we thank for referring you? _____

Signature of DMD/RDH _____ Date _____