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
Y N Aspirin	Y N Digitalis/Heart Medication	Y N Steroids/Cortisone	as Redux or Pondimin. ☐ Yes ☐ No

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 exceeting 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__________

KRAFT & ASSOCIATES

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www.boston-dentist.com

Today's Date: ______________________ E-mail Address: ______________________
Name: ______________________ Last First Mi Mr Mrs Ms Dr Preferred Name: ______________________ ❑ Male ❑ Female
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? ______________________

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