# KRAFT & SCHROTT DENTAL ASSOCIATES

*25 New Chardon Street, Boston, MA 02114*
*Phone: 617-227-4924 • Fax: 617-227-1824 • E-mail: contact@boston-dentist.com*
*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: ________________________________________

**Whom may we thank for referring you to our office?** ______________________________________________________________

## 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: _____

Billing Address: _________________________________________________________________________________________

Street City State Zip

## SPOUSE INFORMATION

His / Her Name: ___________________________________ Birthdate: ___/___/___/ Social Security #: ________________________

Employer: _____________________________________________________ Phone#: (___) ________________________________

## INSURANCE INFORMATION

**Primary Insurance**

Insurance Co. Name: ________________________ Phone #: (___)___________ Group # (Plan, Local or Policy #): _______________

Insured's Name: __________________ Insured's Social Security #: ____________ Insured's Birthdate: ___/___/___/ Relation: ________

Insured's Employer: __________________ Subscriber/Member I.D.#: ___________________________________________________

**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? ❑ Yes ❑ No

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 you use an electric toothbrush? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Are any of your teeth loose? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? ❑ Yes ❑ No

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

If not, what would you change? ______________________________

______________________________________________________

Whiter Teeth? ❑ Yes ❑ No Straighter Teeth? ❑ Yes ❑ No

## 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 any medical specialists? ❑ Yes ❑ No

Please explain: _________________________________________________

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

If yes, how long have you smoked? ___________________________________

How many packs a day do you smoke? ________________________________

**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 biphosphonates? Such as |
| Y N Aspirin | Y N Digitalis/Heart Medication | Y N Steroids/Cortisone | Fosamax or Alendronate. ❑ 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-medicate 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 and it is my responsibility to inform this office of any changes in my medical status. I understand my information will be held in the strictest confidence. I authorize the dentist/dental staff to perform the necessary dental services I may need. I understand that payment for treatment is due on the day of service and payment can be made using cash, check or credit card. I understand that this office requires 48 hours notice for cancellations and to cancel with less than 48 hours will result in a missed appointment charge of $135.

______________________________________________
Signature Date

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 all the dental insurance information given is correct to the best of my knowledge and I assign payment directly to **Boston Dental Restorative Group/ Kraft and Schrott Dental Associates** for all insurance benefits, otherwise payable to me. I hereby authorize the use of this signature on all my insurance submissions, whether manual or electronic. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am responsible for paying for all services rendered. I understand that I am subject to all of my insurance policy's guidelines, restrictions, deductibles, co-payments and maximums. I understand any balance remaining after insurance claims have been processed is a balance that is owed by me. I understand that it is my responsibility to update this office in the event that my insurance policy changes or if I were to become no longer insured. I understand that failure to update this office of the change in that information may result in having to pay for treatment in full without the benefit of insurance.

______________________________________________
Signature Date

We would like to take this opportunity to thank you for allowing us to be your dental team! We appreciate that you have chosen us to provide your care and assure you that it is of the utmost importance to us. The referral of your friends and family is the highest compliment we can receive. Thank you for your trust and confidence in us.

**Signature of DMD/RDH** ______________________________________________ **Date**________________