HIRSHFIELD DENTAL CARE
50 NORTH ST.
MEDFIELD, MA 02052

Today's date_____

WELCOME

Thank you for taking the time to fill out this form. It will enable us to provide quality, personalized dental care for you.

Who may we thank for referring you to our office _____

Patient Information

Birth date _____

Social security number _____ ☐ Male ☐ Female

Name_____
First MI Last

Street address _____

City _____ State _____ Zip _____

Home phone # _____ Business phone # _____

Cell Phone # _____ E-mail_____

Do we have permission to contact you at: ☐ Home ☐ Business ☐ Cell phone ☐ E-mail

Are you: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer name_____ Your occupation _____

Business address _____City_____State_____Zip_____

Spouse's or parents name _____ Work address _____

Work phone _____

If you are a student, name of school or college _____ City _____ State _____

Person to contact in case of emergency _____ Phone # _____

(OVER)

Responsible Party

Name of person responsible for this account _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work Phone _____

Dental Insurance Information

Name of insured _____Relationship to patient_____

Birth date_____Social Security #_____

Name of employer_____Work phone #_____

Address_____City_____State _____Zip_____

Insurance Co._____Group #_____Ins. Phone #_____

Insurance Co. address_____City_____State_____Zip_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? □ NO □ YES
IF YES, PLEASE COMPLETE :

Name of insured _____Relationship to patient_____

Birth date_____Social Security #_____

Name of employer_____Work phone #_____

Address_____City_____State _____Zip_____

Insurance Co._____Group #_____Ins. Phone #_____

Insurance Co. address_____City_____State_____Zip

Confidential Medical History

Personal Physician _____ Phone number_____

Address _____

YES NO

☐ ☐ Have you been hospitalized within the last two years? For what?_____

☐ ☐ Are you currently being treated by a physician? For what? _____

☐ ☐ Are you currently taking any medications or drugs? Please list _____

_____

_____

_____

☐ ☐ Do you take any herbal supplements? Please list _____

_____

☐ ☐ Are you allergic to any drugs? What? _____

_____

☐ ☐ Are you allergic to any metals (found in coins, jewelry etc.)? What?_____

☐ ☐ Are you allergic to latex rubber (found in balloons and dental examination gloves)?

☐ ☐ Do you bleed excessively upon injury?

☐ ☐ Do you ever feel that your mouth is dry?

☐ ☐ Do you smoke?

WOMEN

☐ ☐ Are you/think you may be (circle one) pregnant?

☐ ☐ Are you nursing?

☐ ☐ Do you take birth control pills?

(OVER)

Please check yes or no if you have a history of any of the following conditions:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	**AIDS/ HIV positive**	☐	☐	**Congenital heart defect**	☐	☐	**Hemophilia**	☐	☐	**Sinus problems**
☐	☐	**Anemia**	☐	☐	**Cortisone treatments**	☐	☐	**Hepatitis**	☐	☐	**Skin Rash**
☐	☐	**Alzheimer's**	☐	☐	**Cough, persistent**	☐	☐	**High blood pressure**	☐	☐	**Snoring/sleep apnea**
☐	☐	**Arthritis, Rheumatism**	☐	☐	**Cough up blood**	☐	☐	**Kidney disease**	☐	☐	**Stroke**
☐	☐	**Artificial heart valves**	☐	☐	**Diabetes**	☐	☐	**Liver disease**	☐	☐	**Swelling of feet or ankles**
☐	☐	**Artificial joints**	☐	☐	**Endocarditis**	☐	☐	**Stress or anxiety**	☐	☐	**Thyroid problems**
☐	☐	**Asthma, Emphysema**	☐	☐	**Epilepsy**	☐	☐	**Pacemaker**	☐	☐	**Tobacco habit**
☐	☐	**Back problems**	☐	☐	**Eye surgery**	☐	☐	**Parkinson's**	☐	☐	**Tonsillitis**
☐	☐	**Blood disease**	☐	☐	**Fainting or dizziness**	☐	☐	**Psychiatric care**	☐	☐	**Ulcer**
☐	☐	**Cancer**	☐	☐	**Glaucoma**	☐	☐	**Radiation therapy**			
☐	☐	**Chemical dependency**	☐	☐	**Headaches**	☐	☐	**Respiratory Disease**			
☐	☐	**Chemotherapy**	☐	☐	**Heart problems**	☐	☐	**Scarlet Fever**			
☐	☐	**Circulatory problems**	☐	☐	**Heart surgery**	☐	☐	**Shortness of Breath**			

Dental Health and Appearance

Reason for today's visit _____

Date of last dental visit _____Date of last dental x-rays_____

What is your primary concern that you would like us to address first? _____

Have you ever had a serious problem associated with dental treatment? ☐ YES ☐ NO
If yes please explain _____

How often do you brush? _____ How often do you floss? _____

Do you ever feel (or have you ever been told) that you don't have fresh breath? _____

Would you like whiter teeth? ☐ YES ☐ NO

Would you like straighter teeth? ☐ YES ☐ NO

Please check any of the conditions that apply to you:

□ Bleeding gums	□ Loose teeth or broken fillings	□ Sensitivity to sweets
□ Clicking or popping jaw	□ Previous periodontal treatment	□ Sensitivity when biting
□ Pain in jaw or face	□ Sensitivity to cold	□ Sores or growths in mouth
□ Food collection between teeth	□ Sensitivity to hot	

Authorization

I certify that I have read and understand the above information to the best of my knowledge and that these questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health. I authorize Dr. Hirshfield to release any information including the diagnosis and records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners.

Further, I authorize and request my insurance company to pay directly to Dr. Hirshfield insurance benefits otherwise payable to me. I understand that my dental insurance carrier will pay less than the actual bill for services. Insurance industry practices make it impossible to determine the exact amount of coverage for dental services. I understand that Dr. Hirshfield's office is not responsible for non-payment or payment less than expected by any insurance carrier. Insurance payments are accepted as a courtesy only. Therefore, I agree to be responsible for payment of all services rendered on my behalf and/or my dependents.

X_____

SIGNATURE OF PATIENT (or parent if a minor) **DATE**