Faneuil Hall Dental Associates

177 State Street, Lobby B
McKinley Building
Boston, MA 02109

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Email: smile@FHDental.com

Mr. Ms._____ Birth date _____/_____/_____ Soc Sec No _____/_____/_____
Mrs. Miss Last Name First Name Middle

Home Address _____ City _____ Zip _____

Cell Phone _____ Home Phone _____ Email _____

Employer & Address _____ Occupation _____ City _____

Person financially responsible (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 _____ Emergency contact info _____

Method of payment (check one) ❑ Cash ❑ Insurance ❑ Check ❑ MC/Visa

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

Medical / Dental History

Medical Physician _____ Address _____ Phone _____

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	❑	❑	13	Liver Disease or Hepatitis (A, B, or C)	❑	❑	
2	High Blood Pressure	❑	❑	14	Kidney Disease	❑	❑	
3	Blood Disease	❑	❑	15	Autoimmune Disease	❑	❑	
4	Rheumatic Fever	❑	❑	16	Asthma	❑	❑	
5	Heart Murmur	❑	❑	17	Tuberculosis	❑	❑	
6	Diabetes	❑	❑	18	AIDS / HIV	❑	❑	
7	Stroke	❑	❑	19	Allergy to (a) Penicillin	❑	❑	
8	Epilepsy	❑	❑	20	(b) Other Antibiotics	❑	❑	Which_____
9	Arthritis	❑	❑	21	(c) Local Anesthetics	❑	❑	
10	Tumor History	❑	❑	22	(d) other	❑	❑	
11	STDs	❑	❑	23	Are you pregnant?	❑	❑	# weeks _____
12	Radiation Treatment	❑	❑					

Remarks

Do you have any present dental complaints? _____ Please describe _____

When were your last dental X-rays 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? _____

If you could change one thing about your smile, what would it be? _____

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) _____

Do you currently receive any TMJ botox therapy or sleep apnea /disorder treatment ? _____

Have you ever experienced acid reflux or had any eating disorders? _____

Do you receive injections for facial esthetic therapy (ie. Botox, dermal fillers)? _____

Do you currently whiten your teeth? If yes, which product? _____

Which genre of music makes you feel most at ease? _____

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 _____