PARK DENTAL GROUP PC
480 PARK STREET, STOUGHTON, MA 02072
781-344-5211

Patient Health History

Patient's Name:_____ Date:_____
Last First MI

Social Security #:_____ Date of Birth:_____

Address:_____
Street Apartment #

_____
City/Town State Zip Code

Phones: (Home) _____ (Cell) _____

(Work) _____Ext._____

Email Address:_____

Patient's Occupation:_____

Name of Employer:_____

Spouse/Guardian Name:_____

Health Information

Date of last Dental Visit:_____ Reason for that visit:_____

Chief dental complaint (if any): _____

Are you under the care of a Physician? ☐ Yes ☐ No Why?:_____

Name of Physician:_____ Phone #:_____

Name and location of Pharmacy you use: _____

Are you allergic to any medications? ☐ Yes ☐ No If so list:_____

Have you ever taken Bisphosphonates? (Examples: Zoneta, Aredia, Fosamax, Boniva, Actonel) ☐ Yes ☐ No

Have you been hospitalized in the last five years? ☐ Yes ☐ No If so for what?_____

Do you use any form of tobacco? ☐ Yes ☐ No How often? _____

Do you use any form of recreational drugs?_____

Are you currently pregnant? ☐ Yes ☐ No

Have you ever had any of the following? (Please check all that apply)

☐ AIDS/HIV	☐ Excessive Bleeding	☐ Liver Disease	☐ Tuberculosis
☐ Seasonal Allergies	☐ Fainting	☐ Cold Sores	☐ IBS
☐ Anemia	☐ Glaucoma	☐ Anxiety Disorders	☐ Artificial Joints
☐ Arthritis	☐ Pacemaker	☐ Ulcers	☐ Asthma
☐ Prostate Disorder	☐ Atrial Fibrillation	☐ Venereal Disease	☐ Blood Disease
☐ Head Injuries	☐ Acid Reflux	☐ Codeine Allergy	☐ Cancer; type: _____
☐ Heart Disease	☐ Radiation Treatment	☐ Penicillin Allergy	☐ Heart Murmur
☐ Hepatitis	☐ Respiratory Problems	☐ Hypo/Hyperthyroid	☐ Osteoporosis
☐ Diabetes Type 1	☐ High Blood Pressure	☐ Rheumatic Fever	☐ **TMD/TMJ Disorder**
☐ Diabetes Type 2	☐ Jaundice	☐ Stroke	☐ Fibromyalgia
☐ Seizures	☐ Kidney Disease	☐ Sinus Problems	☐ Parkinson's Disease
☐ Epilepsy	☐ High Cholesterol	☐ Celiac Disease	☐ Multiple Sclerosis

Other: _____

Are you presently taking any medications (including birth control)? ☐ Yes ☐ No If so list:_____

_____

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Who can we thank for referring you?_____

Account/Insurance Information

Person responsible for account: _____ Phone # _____

Address if different from patient: _____
Street City/Town State Zip

Primary Insurance

Subscriber's Name: _____ Subscriber Date of Birth:_____

Subscriber Social Security # _____ Insurance ID # _____

Subscriber Employer: _____ Phone # _____

Insurance Carrier: _____ Group # _____

_____

Patient's Relationship to Subscriber: _____

Secondary Insurance

Subscriber's Name: _____ Subscriber Date of Birth:_____

Subscriber Social Security # _____ Insurance ID # _____

Subscriber Employer: _____ Phone # _____

Insurance Carrier: _____ Group # _____

_____

Patient's Relationship to Subscriber: _____

ACCOUNTS NOT PAID WITHIN 30 DAYS OF THE DATE OF BILLING STATEMENTS ARE SUBJECT TO A MONTHLY FINANCE CHARGE. MISSED OR CANCELLED APPOINTMENTS WITH LESS THAN A 24 HOUR NOTICE WILL BE SUBJECT TO A $50.00 FEE.

Consent for Services

The undersigned hereby authorizes the doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated and further authorize and consent that the doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand the responsibility for payment for dental service provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless all insurance information has been provided or financial arrangements have been made. In the event of default I (we) promise to pay legal interest of the indebtedness, together with such collections costs and reasonable attorney fees as may be required to effect collection of this note.

Patient's Signature (If over 18): _____Date: _____

Spouse/Guardian Signature: _____ Date: _____

Relationship to patient: _____