Dr. Justin Rivers, D.D.S. **92 Crowell Road** **Chatham, MA 02633**

MEDICAL INFORMATION

Patient Name ______________________ (Last) ______________________ (First) ______________ (Date of Birth) **Telephone** ______________

Medical Doctor's Name ______________________ **Telephone** ______________

Are you under physician's care? ☐ yes ☐ no If yes, explain ______________

Have you ever been hospitalized or had a major operation? ☐ yes ☐ no If yes, explain ______________

Have you ever had a serious head or neck injury? ☐ yes ☐ no If yes, explain ______________

Are you on a special diet? ☐ yes ☐no If yes, explain ______________

Do you use tobacco? ☐ yes ☐ no Specify ______________

Do you use controlled substances? ☐ yes ☐ no Specify ______________

Medications: ______________________

Woman: Are you: pregnant/trying to get pregnant? ☐Nursing ☐ Taking Contraceptives? Specify ______________

Are you allergic to any of the following? ☐ Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics

Other (please explain) ______________________

Have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Stomach Troubles	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Thyroid Disease	☐	☐
Swollen Ankles	☐	☐	Mitral Valve Prolapse	☐	☐	Stroke	☐	☐
Respiratory Problems	☐	☐	Cardiac Pacemaker	☐	☐	Tuberculosis	☐	☐
Emphysema	☐	☐	Heart Attack	☐	☐	Radiation Therapy	☐	☐
Asthma	☐	☐	Irregular heartbeat	☐	☐	Glaucoma	☐	☐
Hay Fever/ Allergies	☐	☐	Angina	☐	☐	Recent Weight loss	☐	☐
Diabetes	☐	☐	Blood Disorder	☐	☐	Epilepsy/Seizures	☐	☐
Kidney Diseases	☐	☐	Cancer	☐	☐	Cholesterol	☐	☐
AIDS/HIV Infection	☐	☐	Arthritis	☐	☐	Other ______________		
Hepatitis/Jaundice	☐	☐	Joint Replacement/Implants	☐	☐			

Dental Questions:

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to heat/ cold/ sweets?	☐	☐
3. Do you feel pain to any of your teeth?	☐	☐
4. Do you have any sores or lumps in your mouth?	☐	☐
5. Have you had any head, neck or jaw injuries?	☐	☐
6. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (Joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
7. Do you have frequent headaches?	☐	☐
8. Do you clench or grind your teeth?	☐	☐
9. Do you bite you lips or cheeks frequently?	☐	☐
10. Have you ever had difficult extractions in the past?	☐	☐
11. Have you ever had prolonged bleeding following extractions?	☐	☐
12. Have you ever had orthodontic treatment?	☐	☐
13. Do you wear dentures or partials?	☐	☐
14. Have you ever received oral hygiene instructions?	☐	☐
15. Do you like your smile?	☐	☐

Medical Updates

Date	Findings	Reviewed by	Date	Findings	Reviewed by

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian______________________**Date**______________