



Failla and DeFrancesco Family Dentistry
Offering Comprehensive Dental Care to Patients of All Ages

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www.fddental.com

Patient's Name: _____

(Last)

(First)

(Middle)

Patient's Date of Birth: _____ **Age:** _____ **Sex:** (M) (F) **Ht:** _____' _____" **Wt.:** _____ lbs

Email Address: _____

Parent or Guardian Person: _____

Address (of responsible person): _____

City, State, Zip Code: _____

Telephone Numbers: _____

(Home)

(Business)

(Cell)

(All appointments will be confirmed 24 hours prior. **Please circle the phone #** you prefer for confirming appointments)

Occupation: _____ **Employer:** _____

Marital Status: (Single) (Married) (Divorced) (Widowed) **Spouse's Name:** _____

Spouse's Employer: _____ **Bus. phone** _____ **Cell** _____

Dental Insurance Co: _____ **Soc.Sec.#:** _____

(Social Security # is required for filing insurance)

Spouses Soc.Sec.#: _____

Emergency contact person: _____ **Phone:** _____

What is the reason for today's visit? _____

Who can we thank for REFERRING YOU? _____

I agree to assume full financial responsibility for all the dental treatment rendered. I consent to the dental procedures and anesthetics that are considered necessary for the proposed treatment that will be fully discussed and understood prior to proceeding. I also permit the release of any information to or from my physician as may be required and attest that the following health history is accurate and fully disclosed to the best of my knowledge.

Signature of Patient, Parent or Guardian

Signature of Dentist/Witness

Date

Name: _____

BP: _____

/

P

Date _____

---(Above for office use only)-----

Dental History: General

Are you having any discomfort at this time? _____ How long since you have seen a dentist? _____

How long since cleaning? _____ Have you ever had gum treatments? _____ When? _____

Are your teeth sensitive to: Heat? Cold? Sweets? Pressure? Where? _____

Do you currently have bleeding gums? _____ Does food wedge between your teeth? _____ Where? _____

Do you clench or grind your teeth? _____ When? _____ Are there any lumps or swelling in your mouth? _____

Have you had your teeth straightened? _____ When? _____ Have you had wisdom teeth extracted? _____

Any pain in or around your ears? _____ Do you hear popping, clicking or snapping when you chew? _____

Do you have any fear of dental treatment? None _____ Mild _____ Moderate _____ Severe _____

Are you comfortable having dental treatment with only local anesthetic? _____

Do you require Antibiotics before Dental Treatment? Yes No

Dental History: Esthetic

Are your teeth: Chipped? Protruding? Hidden? Discolored? Crooked? Large Spaces?

Do you like the shape of your teeth? _____ Are there any fillings, caps you don't like looking at? _____

Do You Like Your Smile? _____ If not, why? _____

Medical History:

Physician's Name: _____ Phone# _____

Date of Last Physical Exam: _____ For what? _____

Are You Taking Any Medications Prescribed by a Physician? (Y) (N) What medications and how much?

Are you allergic to any medications or substances? (Y) (N) List please _____

For Women

Are you taking birth control pills? YES NO

Are you pregnant? YES NO

Are you nursing? YES NO

Have you had Bisphosphonate Therapy? YES NO

Check box if you have taken Aredia or Zometa For how long? _____

Have you had IV Therapy for multiple Myeloma, Metastatic Cancer, Paget's Disease or Osteoporsis?

Have you taken oral Bisphosphonates? Which kind?

Actonel Boniva Fosamax Shelif Didrowel

How long have you been on Bisphosphonate Therapy? _____

Do you have any of the following?: (Please indicate **YES** with a check mark)

Any Heart Disease	<input type="checkbox"/>	Allergies to medicines or drugs	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	Latex Allergy	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	Do you SMOKE or dip snuff?	<input type="checkbox"/>	Fainting or Dizzy Spells	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	How much?		Typhoid Fever	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>
Nervous Problems	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Radiation Treatments	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>
Blood Transfusions	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	Are You Pregnant?	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	AIDS or HIV pos	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Malignancies (Cancer)	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	What kind?	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Rheumatism	<input type="checkbox"/>	Surgery requiring general ane:	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>				

Medical Updates:

Date _____ Changes? _____

Date _____ Changes? _____

Date _____ Changes? _____