David N. Bardwell, D.M.D.
1538 Turnpike St. 114 Executive Park
North Andover, MA 01845
Tel: (978) 683-8855 Fax: (978) 327-6157

PATIENT REGISTRATION

CONFIDENTIAL PATIENT HISTORY

PATIENT'S NAME | BIRTH DATE | AGE | SEX

HOME ADDRESS | CITY | STATE | ZIP | HOME PHONE

NAME OF PATIENT'S EMPLOYER | ADDRESS | BUSINESS PHONE

OCCUPATON | SOCIAL SECURITY #

NAME OF SPOUSE | BIRTH DATE | SOCIAL SECURITY # | EMPLOYER

NAME OF PRIMARY DENTAL INSURANCE CO. | ADDRESS

SUBSCRIBER NAME AND ID # | GROUP #

NAME OF SECONDARY DENTAL INSURANCE CO. | ADDRESS

SUBSCRIBER NAME AND ID # | GROUP #

REFERRED TO OUR OFFICE BY

MEDICAL DOCTOR | ADDRESS | DATE OF LAST VISIT

FORMER DENTIST | ADDRESS | DATE OF LAST VISIT

DATE OF LAST DENTal X-RAYS | FULL MOUTH | BITEWINGS

WHO IS RESPONSIBLE FOR THIS ACCOUNT

DENTAL HISTORY

	YES	NO
1. Have you received proper toothbrushing instructions?		
2. How often do you brush?		
3. Have you received proper flossing instructions?		
4. How often do you use dental floss?		
5. Have you ever had an injection to numb your mouth for dental work?		
6. Have you ever had Nitrous Oxide (laughing gas) for dental work?		
7. Have you ever had any nasal obstructions?		
8. Do you have any unhealed injuries of inflammed areas in or around you mouth?		
9. Are you aware of any swelling or lumps in your mouth?		
10. Do you chew only on one side of your mouth?		
11. Do any of your teeth feel loose?		
12. Do you grind or chench your teeth?		
13. Do you have pain or clicking in your jaw joint when chewing or clenching?		
14. Do you have pain around your ears?		
15. Does food wedge between your teeth?		
if yes, what areas?		
16. Are your teeth sensitive to heat _____ cold _____ sweet _____ air _____ pressure _____		
17. Do you have an unpleasant taste in your mouth or had bad breath at times?		
18. Do your gums bleed?		
19. Have you ever had surgery on your gums?		
If yes, when? _____ Doctor's Name		
20. Have you ever had a serious accident involving head or jaw injuries?		
21. Have you ever had orthodontic treatment?		
22. Have you ever had root canal therapy?		
23. Have you ever had any extractions?		
If yes, date and reasons		
24. Did you have any complications with extractions?		
Excessive or prolonged bleeding? _____ Dry Socket? _____ Other? _____		
25. Have they been replaced by: Fixed Bridge? _____ When? _____		
Removable Partial Denture? _____ When? _____		
Full Dentures? _____ When? _____		
Implants? _____ When? _____		
26. Have you been dissatisfied with any dental treatment in the past?		
27. Do you have fluoridated water?		

DATE _____

SIGNATURE _____
Parent or Guardian if patient is a minor

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP ☐ Heart Rate: ☐

Height: ☐

Weight: ☐

Y N	Conditions
☐ ☐	Abnormal Bleeding
☐ ☐	Alcohol Abuse
☐ ☐	Allergies
☐ ☐	Anemia
☐ ☐	Angina Pectoris
☐ ☐	Arthritis
☐ ☐	Artificial Bones
☐ ☐	Artificial Heart Valve
☐ ☐	Asthma
☐ ☐	Blood Transfusion
☐ ☐	Bruise Easily
☐ ☐	Cancer- Chemotherapy
☐ ☐	Colitis
☐ ☐	Congenital Heart Defect
☐ ☐	Diabetes
☐ ☐	Difficulty Breathing
☐ ☐	Drug Abuse
☐ ☐	Emphysema
☐ ☐	Epilepsy
☐ ☐	Fainting Spells
☐ ☐	Fever Blisters
☐ ☐	Frequent Headaches

Y N	Conditions
☐ ☐	Glaucoma
☐ ☐	HIV+ AIDS
☐ ☐	Heart Attack
☐ ☐	Heart Surgery
☐ ☐	Hemophilia
☐ ☐	Hepatitis A
☐ ☐	Hepatitis B
☐ ☐	Hepatitis C
☐ ☐	High Blood Pressure
☐ ☐	Kidney Problems
☐ ☐	Liver Disease
☐ ☐	Low Blood Pressure
☐ ☐	Mitral Valve Prolapse
☐ ☐	Pace Maker
☐ ☐	Pain In Jaw Joints
☐ ☐	Pneumocystitis
☐ ☐	Radiation Therapy
☐ ☐	Rheumatic Fever
☐ ☐	Seizures
☐ ☐	Shingles
☐ ☐	Sickle Cell Disease
☐ ☐	Sinus Problems

Y N	Conditions
☐ ☐	Stroke
☐ ☐	Thyroid Problems
☐ ☐	Tuberculosis
☐ ☐	Ulcers
☐ ☐	Venereal Disease
☐ ☐	Yellow Jaundice

Y N	Allergies
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Erythromycin
☐ ☐	Jewelry
☐ ☐	Latex
☐ ☐	Metals
☐ ☐	Penicillin
☐ ☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)