PDA DENTAL GROUP
PEDIATRIC | ORTHODONTIC | ADULT

955 Main Street, Suite 101 | Winchester, MA 01890 | 781-729-1900
54 Haven Street | Reading, MA 01867 | 781-944-7799
www.pdadentalgroup.com

PATIENT INFORMATION (Confidential)

Patient's Last Name _____ Patient's First Name _____ Preferred Name _____ M.I. ___

Social Security # _____ Home Address _____ City, State _____ Zip Code _____

Birthdate _____ Home Phone Number _____ Cell Phone Number _____ Email Address _____

Martial Status: ☐ Minor ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed Gender: _____

If Student, Name of College/University _____ College/University City, State _____ Full/Part Time Student _____

Responsible Party for Account, IF NOT PATIENT _____ Relationship to Patient _____ Social Security # _____

Responsible Party's Address _____ Home Phone Number _____ Cell Phone Number _____

Responsible Party's Email Address _____ Birthdate _____ Occupation/Employer _____ Work Phone Number _____

Emergency Contact Name _____ Relationship to Patient _____ Phone Number _____

Do you want to give us permission to speak to anyone else about your treatment or bill? ☐ Yes ☐ No

If yes, please specify who: _____

How did you hear about us? ☐ PDA Patient:_____ ☐ PDA Employee:_____

☐ Social Media:_____ ☐ Family/Friends:_____

☐ Referral:_____ ☐ Community Events:_____ ☐Other:_____

Name of Previous Dentist / Location _____ Last Exam Date _____

Have you had or are experiencing any of the following:

☐ Yes	☐ No	Bleeding while brushing or flossing	☐ Yes	☐ No	Frequent headaches
☐ Yes	☐ No	Teeth sensitivity to hot/cold liquids or foods	☐ Yes	☐ No	Clench or grind your teeth
☐ Yes	☐ No	Teeth sensitivity to sweet/sour liquids or foods	☐ Yes	☐ No	Bite your lips or cheeks frequently
☐ Yes	☐ No	Painful teeth	☐ Yes	☐ No	Difficult extractions
☐ Yes	☐ No	Sores or lumps in or near your mouth	☐ Yes	☐ No	Prolonged bleeding following extractions
☐ Yes	☐ No	Head, neck or jaw injuries	☐ Yes	☐ No	Orthodontic treatment (braces, retainers)
☐ Yes	☐ No	Clicking in your jaw	☐ Yes	☐ No	Dentures or partials
☐ Yes	☐ No	Pain (join, ear, side of face)	☐ Yes	☐ No	Specific oral hygiene instruction
☐ Yes	☐ No	Difficulty in opening or closing your mouth	☐ Yes	☐ No	Nervous about dental treatment
☐ Yes	☐ No	Difficulty in chewing	☐ Yes	☐ No	Do you like your smile?

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MEDICAL HISTORY

Patient Name _____ Birthdate _____

Physician _____ Office Phone Number _____ Last Exam Date _____

1) Any concerns that you would like to discuss with the dentist? _____
2) Are you undergoing medical treatment? ☐ **Yes** ☐ **No**
   If yes, please explain:_____
   _____
   _____
3) Have you been hospitalized for any surgical operations or serious illness? ☐ **Yes** ☐ **No**
   If yes, please explain, including the surgery names and dates: _____
   _____
   _____
   _____
4) Are you taking any medications, including any non-prescription medications? ☐ **Yes** ☐ **No**
   If yes, please list below.

DRUG	DOSE	FREQUENCY	REASON

5) Have you ever taken Fen-PHen/Redux? ☐ **Yes** ☐ **No**
6) Have you ever taken Fosamax, Boniva, Actonel, or any medications containing bisphosphonates? ☐ **Yes** ☐ **No**
7) Have you ever had a joint replacement? ☐ **Yes** ☐ **No**
   If yes, what _____ and when _____
8) Have you ever been told by your doctor to take antibiotics prior to dental work? ☐ **Yes** ☐ **No**
9) Do you use tobacco in any form? ☐ **Yes** ☐ **No**
   If yes, please explain: _____
10) Do you use recreational drugs? ☐ **Yes** ☐ **No**
   ☐ **Smoking** ☐ **Vaping** ☐ **Smokeless Tobacco** ☐ **Other**
   If other, please list: _____
11) Are you wearing contact lenses? ☐ **Yes** ☐ **No**
12) Are you allergic to or have had any reactions to the following?

Local Anesthetics	☐ **Yes** ☐ **No**		
Barbiturates	☐ **Yes** ☐ **No**		
Iodine	☐ **Yes** ☐ **No**		
Any Metals (nickel, mercury, etc.)	☐ **Yes** ☐ **No**		
Latex	☐ **Yes** ☐ **No**		
Sedatives	☐ **Yes** ☐ **No**		
Aspirin	☐ **Yes** ☐ **No**		
Penicillin	☐ **Yes** ☐ **No**		
Other Antibiotics	☐ **Yes** ☐ **No**	If yes, please list: _____	
Food	☐ **Yes** ☐ **No**	If yes to food, please list:_____	
Other	☐ **Yes** ☐ **No**	If yes to other, please list:_____	

13) Do you have a persistent cough or throat clearing not associated with a known illness lasting over 3 weeks? ☐ **Yes** ☐ **No**
14) Women Only:
   a. Are you pregnant or think you may be pregnant? ☐ **Yes** ☐ **No**
   b. Are you nursing? ☐ **Yes** ☐ **No**
   c. Are you taking oral contraceptives? ☐ **Yes** ☐ **No**

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MEDICAL HISTORY

Patient Name _____ Birthdate _____

15) Have you had or ever been diagnosed with any of the following conditions? Please check **yes** or **no**.

☐ Yes ☐ No High Blood Pressure	☐ Yes ☐ No Epilepsy/Convulsions	☐ Yes ☐ No Sexually Transmitted Disease
☐ Yes ☐ No Heart Attack	☐ Yes ☐ No Diabetes	☐ Yes ☐ No Stomach Troubles/Ulcers
☐ Yes ☐ No Low Blood Pressure	☐ Yes ☐ No Bleeding/Blood Clotting	☐ Yes ☐ No Easily Winded
☐ Yes ☐ No Heart Disease	☐ Yes ☐ No Bone/Joint Problems	☐ Yes ☐ No Stroke
☐ Yes ☐ No Cardiac Pacemaker	☐ Yes ☐ No AIDS/HIV	☐ Yes ☐ No Hay Fever/Allergies
☐ Yes ☐ No Heart Murmur	☐ Yes ☐ No Thyroid Problems	☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Angina	☐ Yes ☐ No Frequently Tired	☐ Yes ☐ No Radiation Therapy
☐ Yes ☐ No Mitral Valve Prolapse	☐ Yes ☐ No Anemia	☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Chest Pains	☐ Yes ☐ No Emphysema	☐ Yes ☐ No Recent Weight Loss
☐ Yes ☐ No Rheumatic Fever	☐ Yes ☐ No Cancer	☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Swollen Ankles	☐ Yes ☐ No Arthritis	☐ Yes ☐ No Respiratory Problems
☐ Yes ☐ No Fainting/Seizures	☐ Yes ☐ No Joint Replacement/Implant	☐ Yes ☐ No Other_____
☐ Yes ☐ No Asthma	☐ Yes ☐ No Hepatitis/Jaundice	

Additional Comments

_____

_____

_____

_____

_____

_____

_____

Authorization and Release: I certify that I have read and understand this information to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in medical status. I hereby give permission to PDA Dental Group to provide dental treatment to me and/or my child, which the doctor deems necessary and appropriate. Routine treatment may include, but not limited to, cleanings, exams, topical and local anesthetics (injections), fillings, radiographs, etc.

Responsible Party's Signature_____ **Date**_____