359 Boylston St. #6
Boston, MA 02116
(617)262-1422

27 E Emerson St.
Melrose, MA 02176
(781)665-3442

V MOURMOUTIS DMD PC
BOSTON TEETH ASSOCIATES

MOUTH HERO

PATIENT INFORMATION

Name:_____ Birthdate:_____
Home phone:_____ Cell phone:_____
Email :_____
Address:_____ City:_____ State:_____ Zip:_____
Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or parent's employer:_____ Work phone:_____
Business address:_____ City:_____ State:_____ Zip:_____
Spouse or parent's name:_____
Employer:_____ Work phone:_____
Person to contact in case of emergency:_____ Phone:_____
Email:_____ Relationship to patient:_____

RESPONSIBLE PARTY

Name of person responsible for this account:_____ Relationship to patient:_____
Address:_____ City:_____ State:_____ Zip:_____
Home phone:_____ Cell phone:_____
Email:_____ Birthdate:_____
Is this person currently a patient in our office? ☐ Yes ☐ No Driver's License #:_____
Employer:_____ Work phone:_____ Member ID:_____

INSURANCE INFORMATION

Name of insured:_____ Relationship to patient:_____
Birthdate:_____ Member ID:_____ Date employed:_____
Name of employer:_____ Work phone:_____
Employer address:_____ City:_____ State:_____ Zip:_____
Insurance company:_____ Group #:_____
Insurance company address:_____ City:_____ State:_____ Zip:_____
Do you have any additional insurance? ☐ Yes ☐ No If YES, complete the following
Insurance company:_____ Group #:_____

Who may we thank for referring you?: _____

Date:

MEDICAL HISTORY

Physician: _____ Office phone: _____ Date of last exam: _____

Are you under medical treatment now? ☐ Yes ☐ No

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ☐ Yes ☐ No

Are you on any medication(s), including non-prescription? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever or are you currently taking a bisphosphonate? (such as Fosamax) ☐ Yes ☐ No

Do you use Tobacco? ☐ Yes ☐ No

Do you use alcohol, cocaine or other drugs? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Are you pregnant or think you may be pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you taking oral contraceptives? ☐ Yes ☐ No

Are you allergic to or have reactions to the following:

☐ Local anesthetics (e.g. Novocaine) ☐ Sedatives ☐ Latex rubber ☐ Iodine

☐ Penicillin or Antibiotics ☐ Barbiturates ☐ Sulfa drugs ☐ Aspirin

Other (please list): _____

Do you have or have you ever had any of the following?

☐ AIDS or HIV Infection ☐ Emphysema ☐ Hepatitis/Jaundice ☐ Respiratory problems

☐ Anemia ☐ Epilepsy/Convulsions ☐ High blood pressure ☐ Rheumatic fever

☐ Angina ☐ Fainting/Seizures ☐ Joint replacement/Implant ☐ Stroke

☐ Arthritis ☐ Frequently tired ☐ Kidney disease ☐ Sexually Transmitted Disease

☐ Asthma ☐ Glaucoma ☐ Leukemia ☐ Stomach trouble/Ulcers

☐ Cancer ☐ Hay fever allergies ☐ Liver disease ☐ Swollen ankles

☐ Cardiac pacemaker ☐ Heart attack ☐ Low blood pressure ☐ Thyroid problem

☐ Chest pains ☐ Heart disease ☐ Mitral valve prolapse ☐ Tuberculosis

☐ Diabetes ☐ Heart murmur ☐ Radiation therapy

☐ Easily winded ☐ Heart trouble ☐ Recent weight loss

Other (please list): _____

Date:

DENTAL HISTORY

Do your gums bleed while brushing or flossing?	☐ Yes	☐ No
Do you have any sores or lumps in or near your mouth?	☐ Yes	☐ No
Have you had prolonged bleeding after extractions?	☐ Yes	☐ No
Have you had difficult extractions in the past?	☐ Yes	☐ No
Do you bite your lips or cheeks frequently?	☐ Yes	☐ No
Are your teeth sensitive to hot or cold?	☐ Yes	☐ No
Are your teeth sensitive to sweet or sour?	☐ Yes	☐ No
Do you feel pain to any of your teeth?	☐ Yes	☐ No
Have you had any head, neck, or jaw injuries?	☐ Yes	☐ No
Do you have frequent headaches?	☐ Yes	☐ No
Do you clench or grind your teeth?	☐ Yes	☐ No
Have you had any orthodontic treatment?	☐ Yes	☐ No
Have you ever received oral hygiene instructions regarding the care of your teeth and/or gums?	☐ Yes	☐ No
Do you wear dentures or partials?	☐ Yes	☐ No

If yes, date of placement:

Have you ever experienced any of the following:

☐ Difficulty chewing ☐ Pain (jaw, joint, ear, side of face)

☐ Jaw clicking ☐ Difficulty opening or closing jaw

AUTHORIZATION & RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

SIGNATURE: _____

Signature of patient (or parent/guardian if patient is a minor)

DATE: _____