



TORRISI & BURBA

DENTAL ASSOCIATES

380 Merrimack Street, Suite 3C - Methuen, MA 01844 - Tel: 978.681.7740

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date _____ Patient's Name _____
Last First Middle
Address _____ City _____ State _____ Zip _____
Home Ph# (____) _____ Work Ph# (____) _____ Cell Ph# (____) _____
Soc. Sec. # _____ Email _____
Sex M F Age _____ Birthdate _____ Single Married Widowed Divorced
Patient Employed by _____ Occupation _____
Business Address _____
Whom may we thank for referring you? _____
In case of emergency who should be notified? _____ Phone(____) _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Middle
Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (If different from patient's) _____ Phone (____) _____
City _____ State _____ Zip _____
Person Responsible Employed By _____ Occupation _____
Business Address _____ Business Phone (____) _____
Insurance Company _____ Group # _____
Insurance Co. Address _____ Phone (____) _____
Is patient covered by additional dental insurance? Yes No
If yes, please complete the following secondary insurance information.
Insured's Name _____ Relation to Patient _____
Insured's Soc. Sec. # _____ Insured's Birthdate _____
Insurance Company _____ Group # _____
Insurance Co. Address _____ Phone (____) _____

Please Complete Both Sides

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____ Phone (____) _____

Check (✓) if you have had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Are you currently under physicians care? Yes No If yes, why _____

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No

Taking birth control pills/Hormone Therapy Yes No

Check (✓) if you have or have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Emphysema | <input type="checkbox"/> HIV/AIDS/ARC | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain TMJ/TMD | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Radiation Treatment | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | |
| <input type="checkbox"/> Circulatory Problems | | <input type="checkbox"/> Rheumatic Fever | |

MEDICATIONS

List medications you are currently taking:

ALLERGIES

AUTHORIZATION

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. If there is any change in my medical status, I will inform the dentist. I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.