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

Thomas P. Torrisi, DDS, PC.

380 Merrimack street | Suite 3C • Methuen, MA 01844 (978)681-7740

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Please select/verify the following medical alerts:

- ☐ *Pre-Med
- ☐ ADHD/ADD
- ☐ Amoxicillin
- ☐ aspirin
- ☐ Autoimmune disease
- ☐ Cholesterol
- ☐ Diabetes
- ☐ erythomycin
- ☐ Flagyl
- ☐ Heart Murmur
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ MEDS-Blood Thinners
- ☐ Nervousness
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Zithromycin
- ☐ *Pre-Med
- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Blood Disease
- ☐ Clindamycin
- ☐ Difficult Anesthia
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Heart Valve Replaced
- ☐ Immunosuppressed
- ☐ knee replacement
- ☐ MEDS-SEE LIST
- ☐ NSAIDS
- ☐ Penicillin
- ☐ Respiratory Problems
- ☐ Sleep Apnea
- ☐ Sulfa
- ☐ Tumors
- ☐ Acid Reflux
- ☐ Allergy - Latex
- ☐ anxiety
- ☐ Augmentin
- ☐ Bone Density issue
- ☐ Crohns Disease
- ☐ Dizziness
- ☐ Fainting
- ☐ Head Injuries
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Latex
- ☐ Minocin
- ☐ Nuts/Tree nuts
- ☐ percocet
- ☐ Rheumatic Fever
- ☐ STD
- ☐ Tetracycline
- ☐ Ulcers
- ☐ Addiction
- ☐ Allergy - Medication
- ☐ Arthritis
- ☐ Autism Spectrum
- ☐ Cancer
- ☐ Depression/Anxiety
- ☐ Epilepsy/Seizures
- ☐ Flagyl
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Liver Disease
- ☐ Morphine
- ☐ OCD
- ☐ pregnancy
- ☐ Seasonal Allergies
- ☐ Stomach Problems
- ☐ Thyroid Disorder
- ☐ z OTHER

Please clarify any medical condition(s) listed above or any additional medical conditions: *

_____

_____

_____

Please list any additional allergies including allergies to medications and environmental and food: *

_____

_____

Please list all current medications: *

_____

_____

_____

_____

_____

_____

Primary care physcian name, telephone, location: *

Tobacco use/ history: *

Alcohol consumption: *

Recent Hospitalization or Major Illness or Surgery: *

Do you have any artifical joints or hear valve replacements? If yes, please describe: *

Do you require premed antibiotics prior to dental procedures? If yes, please explain. *

Please select if any of the following apply? *

☐ Snoring ☐ CPAP use ☐ Daytime sleepiness ☐ Wake up at night gasping for air

☐ NONE OF THE ABOVE

WOMEN ONLY/ Please select if any of the following apply:

☐ Pregnant ☐ Nursing ☐ Taking birth control pills ☐ NONE OF THE ABOVE

Additional Notes:

Response Date: ___/___/_____