BRAINTREE FAMILY DENTAL
381 WASHINGTON ST
BRAINTREE MA 02184

Patient information

PATIENT NAME:_____**BIRTH DATE**_____

HOME PHONE: _____ **CELL PHONE :**_____

ADDRESS:_____**CITY:**_____ **ST.**_____ **ZIP CODE:**_____

☐ **I WOULD LIKE TO RECEIVE CORRESPONDENCES VIA EMAIL.**

E-MAIL: _____@_____

(IF YOU HAVE MASSHEALTH YOU DON'T HAVE TO FILL OUT SUBSCRIBER INFORMATION)
(SUBSCRIBER NAME_____**D/O/B**_____**SUBSCRIBER ID**_____
(TYPE OF INSURANCE_____ **SSN#** _____

GENERAL HEALTH (CHECK ONE) EXCELLENT ___ GOOD ___ FAIR ___ POOR ____
(PRIMARYCARE)
MEDICAL DOCTOR_____**ADDRESS**_____**PHONE:** _____

ARE YOU TAKING ANY MEDICATIONS? YES_____ **NO**_____
WHAT MEDICATION AND REASON:

Have you ever been hospitalized OR ANY SURGERY? NO ___ YES __ for what and date of last visit: ?
_____

ALLERGIES TO: ___ **PENNICILLIN ,** __ **LOCAL ANESTHESIA,** __ **CODEINE,.** __ **LATEX**
OTHERS_____

DO YOU NEED TO BE PRE MEDICATED BEFORE SEEING THE DOCTOR TODAY: YES _____ **NO** _____

TAKING BIRTH CONTROL PILLS? YES ___ **NO**___. **ARE YOU PREGNANT? YES** ___ **NO**___
ARE YOU SUBJECT TO PROLONGED BLEEDING? YES ____ **NO**_____

(CHECK ALL APPLICABLE) ✓

_____PAIN IN JAW JOINTS	_____BLOOD TRANSFUSION	__PHYCHIATRIC TX
____ GLAUCOMA	___ HEART VALVE	__ANEMIA
_____ DRUG ADDICTION	____ CHEMOTHERAPY	__RHEUMATICAL FEVER
_____HEART DISEASE	__ JAUNDICE	__ ULCER
_____HIGH CHOLESTEROL	_____ EPILEPSY	_ARTHRITIS
_____-HIGH/ABNORMAL BLOOD PRESSURE	___ HAY FEVER	___HEPATITIS A B C
_____DIABETES	____ SINUS	__LIVER DISEASE
_____ TUBERCULOSIS OR LUNG DISEASE	__ ASTHMA/ENPHYSEMA	__HIP REPLACEMENT
_____STROKE	__ CONGENITAL HEART LESIONS	____ SMOKER
_____SEIZURES	_____ HERPES	___ANGINA PECTORIS
_____VENERAL DISEASE	____ KIDNEY PROBLEMS	__ARTIFICIAL HEART VALVE
_____ HEART MURMUR	_____ AIDS OR HIV VIRUS	
_____ ARTIFICIAL JOINTS OR ANY METAL IMPLANTS		

PATIENT/PARENT/GUARDIAN SIGNATURE:_____**DATE:**_____
Dr. signature _____