

IcuSmile Specialty Clinic

Myra Brennan DMD, Prosthodontist
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Hingham, MA 02043
781.361.3000

PATIENT INFORMATION ONLY

Patient _____ Date of Birth _____ Age _____
Address _____
STREET TOWN STATE ZIP
Mailing address if different _____
E-Mail Address _____
Home Phone# _____ Work Phone# _____ Cell Phone# _____
SS# _____ Marital Status: Single Married Minor Sex: Male Female
Patient Employer _____ Occupation _____
Address _____
Are you a college student? School _____ Address _____
In case of emergency contact _____ Relationship _____ Phone# _____
Family Dentist _____ Phone# _____
Who may we thank for referring you? _____ **I will be paying today by:** Cash Check Credit Card

IF DIFFERENT THAN PATIENT

Name of person financially responsible _____ Date of Birth _____
Address _____
STREET TOWN STATE ZIP
Home Phone# _____ Work Phone# _____ Cell Phone# _____
Employer _____ Address _____
SS# _____ Relationship to you _____

Release: I authorize the dentist to perform diagnostic procedures and treatments as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment to other treating doctors. I understand that I am responsible for all costs of dental treatment. • I attest to the accuracy of the information on this page.

PATIENT OR LEGAL GUARDIAN SIGNATURE _____ **DATE** _____

HEALTH HISTORY:

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit? _____

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Height _____ Weight _____ Age _____ Are you in good health? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have there been any changes in your general health in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you under the care of a physician? Date of last visit _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, for what are you being treated? _____ | | |
| 4. Have you had any illness, operation or been hospitalized in the past five years? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, describe _____ | | |
| 5. Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, describe where _____ | | |
| 6. Do you have a prosthetic joint / implant? If so, describe where _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a heart valve replacement or vascular graft? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had general anesthesia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you, or a family member, had any unusual or serious reactions to general anesthesia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> |

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
11. Rheumatic fever?			
12. Damaged heart valves / mitral valve prolapse?			
13. Heart murmur?			
14. High blood pressure?			
15. Low blood pressure?			
16. Chest pain / angina?			
17. Heart attack(s)?			
18. Irregular heart beat?			
19. Cardiac pacemaker?			
20. Heart surgery?			
21. Pneumonia, bronchitis, chronic cough?			
22. Asthma?			
23. Hay fever / sinus problems?			
24. Snoring?			
25. Sleep apnea / CPAP?			
26. Difficult breathing / other lung trouble?			
27. Tuberculosis?			
28. Emphysema?			
29. Do you smoke? If so, number of packs a day _____			
30. Do you use chewing tobacco?			
31. Blood transfusion?			
32. Blood disorder such as anemia?			
33. Bruise easily?			
34. Bleeding tendency / abnormal bleed?			
35. Hepatitis, jaundice, or liver disease?			
36. Infectious mononucleosis?			
37. Gallbladder trouble?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
38. Fainting spells or dizziness?			
39. Convulsions / epilepsy?			
40. Stroke / TIA?			
41. Thyroid trouble?			
42. Diabetes?			
43. Low blood sugar?			
44. Kidney trouble?			
45. High cholesterol?			
46. Are you on dialysis?			
47. Swollen ankles / arthritis / joint disease?			
48. Osteoporosis / osteopenia?			
49. Osteonecrosis?			
50. Stomach / acid reflux?			
51. Contagious diseases?			
52. Sexually transmitted diseases?			
53. Problems with immune system? Possibly from medication / surgery, etc.			
54. Delay in healing?			
55. A tumor or growth?			
56. Cancer / radiation therapy / chemotherapy?			
57. Chronic fatigue / night sweats?			
58. Are you on a diet?			
59. A history of alcohol abuse?			
60. A history of drug abuse?			
61. Contact lenses?			
62. Eye disease / glaucoma?			
63. Mental health problems / anxiety / depression?			
64. A removable dental appliance?			
65. Pain or clicking of jaws when eating?			

PATIENT DISCLOSURE INSTRUCTIONS

I wish to be contacted in the following manner (check all that apply):

- Text (_____) _____
- E-Mail _____
- Cell Phone _____
- Home Phone _____
- Work Phone _____
- OK to leave a detailed message
- Leave a call back number only
- OK to confirm appointment

I allow you to give my clinical information to, or answer questions from (check all that apply):

- Spouse
- Parent
- Child
- None
- Other (specify) _____

I allow you to give my financial information to, or answer questions from (check all that apply):

- Spouse
- Parent
- Child
- None
- Other (specify) _____

I want Myra Brennan DMD to e-mail my estimate via:

- Encrypted e-mail
- Non-encrypted e-mail *(with the understanding that non-encrypted can be viewed by someone other than the intended recipient)*

Signature of patient (Parent or Guardian if Minor)

Date

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ X
Signature of patient (Parent or Guardian if Minor)

Date

X _____ X
Reviewed by

Date

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Signature of patient (Parent or Guardian if Minor)

X _____
Date

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____
Signature of patient (Parent or Guardian if Minor)

X _____
Date