Dr. I.R. Santoso
Dental Office

133 Church Street
Northborough, MA 01532

Patient Information

Name: _____(first) _____ (middle) _____ (last)

Title (Mr/Ms/Mrs/etc): _____ Family status (circle): Married Single Child Other

Date of Birth: _____ (mm/dd/yyyy)

Phone: (Home) _____ (Mobile) _____

(Work) _____

Please indicate preferred number.

Address (street, city, state, zip): _____

_____

Whom may we thank for referring you to our practice?

□ Family, friend, or other person
□ Internet
□ Other: _____

Emergency contact name: _____

Emergency contact relationship: _____

Emergency contact phone number: _____

Medical and Dental History

Have you had any change of health in the past year? If yes, please explain.

_____

_____

How often do you see a health care provider?

□ Less than once a year

□ Once a year

□ More than once a year

Primary care physician name: _____

Primary care physician address: _____

Primary care physician phone number: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone number: _____

Are you currently being treated by anyone other than your primary care physician? If yes, please list the names of your health care providers.

_____

_____

Do you have any serious medical problems at this time?

_____

□ Do you smoke?

□ Have you smoked?

Health issues:

_____

_____

Medication list:

_____

_____

Allergy list (medications, materials, etc.):

_____

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Please select if any of the following apply to you:

□ High blood pressure
□ Heart angina
□ Heart attack
□ Stroke
□ Heart murmur
□ Heart surgery
□ Pacemaker
□ Rheumatic fever
□ Bacterial endocarditis
□ Arthritis
□ Cancer
□ Diabetes
□ Liver disease
□ Kidney disease
□ Bleeding disorders
□ Dizziness/fainting
□ Nervous/mental disorders
□ Epilepsy
□ Hepatitis A
□ Hepatitis B
□ Hepatitis C
□ Jaundice
□ Respiratory problem
□ Slow healing time
□ Venereal disease
□ Glaucoma
□ HIV/AIDs
□ Asthma
□ Head injuries
□ Osteoporosis
□ Radiation treatment
□ Alzheimer's disease
□ Joint replacement
□ Stomach problems
□ Stomach ulcers
□ Sinus problems
□ Autoimmune disease
□ Sore/enlarged lymph nodes
□ Other not listed

What is the reason for your dental visit today?

_____

When was your last visit to the dentist?

_____

Prior dentist's name, address, and phone number:

_____

□ Do your gums bleed when you brush or floss?
□ Do you grind your teeth?
□ Have you ever had instruction on the correct method of brushing and flossing your teeth?
□ Do your teeth feel sensitive to cold or hot temperatures?

Please explain if you mark YES to any of the above or if you have any other dental concerns:

_____

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Authorization

I hereby certify that I have read and understood the previous information and that it is accurate and true to the best of my knowledge.

Date: _____

Signature: _____

Primary Insurance Information

Do you have dental insurance? (circle) Yes No

If yes, please fill out the following information. In order to process your claim, we need the subscriber ID # and the subscriber date of birth.

Name of Insured: _____(first) _____ (last) _____ (M.I.)

Insured's Date of Birth: _____ (mm/dd/yyyy)

ID #: _____ Group #: _____

Insured's address (street, city, state, zip code): _____

_____

Insured's Employer Company Name: _____

Employer address (street, city, state, zip code): _____

_____

Patient's relationship to insured (circle): Self Spouse Child Other: _____

Insurance Plan Name: _____

Insurance address (street, city, state, zip code): _____

_____

Insurance company phone number: _____

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Secondary Insurance Information

Name of Insured: _____(first) _____ (last) _____ (M.I.)

Insured's Date of Birth: _____ (mm/dd/yyyy)

ID #: _____ Group #: _____

Insured's address (street, city, state, zip code): _____

_____

Insured's Employer Company Name: _____

Employer address (street, city, state, zip code): _____

_____

Patient's relationship to insured (circle): Self Spouse Child Other: _____

Insurance Plan Name: _____

Insurance address (street, city, state, zip code): _____

_____

Insurance company phone number: _____