Masterpiece Dentistry at Copley Today's date: _____

John P. Pappas, DMD, 441 Stuart Street 4th floor, Boston, MA 02116, 617-266-6020, info@copleysmiles.com

Welcome, and thank you for choosing us for your dental care. To ensure the best and safest care possible, please complete both sides of this medical/dental history form. All information is completely confidential.

Patient Registration

Name: _____ Preferred name:_____

Address: _____ City: _____ Zip: _____

Date of Birth: _____ E-Mail: _____

Cell or home phone: _____ Work phone: _____

Male: _____ Female: _____ Married: _____ Single: _____

Emergency Contact: _____ Relationship: _____ _____ Phone: _____

(If you have dental insurance, please present your card with this form at the front desk)

Whom can we thank for inviting you to come to our office: _____

Medical History

Physician's Name: _____ Phone: _____ Last Exam: _____

. Are you receiving medical treatment now? Reason: _____

. Have you had any surgeries within the past two years? Describe: _____

. List all current medications including prescription and over the counter: _____

_____ _____

. Do you take or have you ever taken bone loss prevention drugs such as Fosamax, Boniva, etc. ? Yes___ No___

. Do you have allergic reactions to any medications? Please specify: _____

. Are you allergic or have sensitivity to latex ? Yes ___ No___ Allergy to other substance? Specify: _____

Indicate which of the following you have had, or presently have. Please circle "yes" or "no" to each item :

Heart Disease …	Yes	No	Diabetes…	Yes	No	Hepatitis ... if Yes, circle	A	B	C No
Heart Murmur…	Yes	No	HyperThyroid	Yes	No	AIDS/HIV+…	Yes	No	
High Blood Pressure …	Yes	No	HypoThyroid …	Yes	No	Cold Sores …	Yes	No	
Low Blood Pressure …	Yes	No	Emphysema …	Yes	No	Hemophilia…	Yes	No	
Pacemaker…	Yes	No	C.O.P.D …	Yes	No	Jaundice …	Yes	No	
Artificial Heart Valve …	Yes	No	Tuberculosis…	Yes	No	Tourettes …	Yes	No	
Mitral Valve Prolapse…	Yes	No	Asthma …	Yes	No	Neurological Disorders…	Yes	No	
Atrial Fibrillation …	Yes	No	Hay Fever …	Yes	No	Epilepsy or Seizures…	Yes	No	
Swollen Ankles…	Yes	No	Cancer…	Yes	No	Fainting Spells …	Yes	No	
Stroke …	Yes	No	Radiation …	Yes	No	Anxiety …	Yes	No	
Artificial joint …	Yes	No	Chemotherapy	Yes	No	Psychiatric Care…	Yes	No	
Artificial soft tissue …	Yes	No	Kidney Disease	Yes	No	Multiple Sclerosis …	Yes	No	
Rheumatic Fever…	Yes	No	Arthritis …	Yes	No	Other not listed _____			

**Women only*: are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Dental History

Do you require premed antibiotics before dental treatment due to heart condition or artificial joint? Yes No
Reason for your visit today: _____
Previous Dentist: _____ Address:_____ Phone: _____
Date of last dental visit: _____ Date of last cleaning: _____ Date of last x-rays: _____

How often do you brush your teeth? _____ How often do you floss? _____
What else do you use to clean your teeth? _____
Do you use a fluoride rinse in addition to what is in your toothpaste ? Yes No

Circle all that apply: my teeth are sensitive to: hot, cold, sweets, chewing, air
Do you have bad breath? Yes No Don't know Do your gums bleed or hurt? Yes No
Have your parents had gum disease or tooth loss? Yes No
Do you clench or grind your teeth while awake or asleep? Yes No Don't Know
Do you ever have jaw pain or soreness? Yes No
Do you snore or have sleep disorders? Yes No Don't Know
Circle all that apply: I have frequent: headaches, neck pain, shoulder aches
Do you wear a nightguard? Yes No Do you wear a sleep apnea appliance? Yes No

Do you smoke? Yes No Do you chew tobacco? Yes No
Do you have missing teeth? Yes No Are you happy with your smile? Yes No

Are you interested in whitening your teeth? Yes No
Are you interested in straightening your teeth? Yes No
Do you feel nervous or anxious about having dental treatment? Yes No
If yes, why? _____

Please add anything else you feel is important for us to know about you: _____
_____

Consent for Treatment

I authorize Dr. Pappas and his dental team to take any necessary x-rays, study models, photographs, and other diagnostic aids to make a thorough diagnosis. Upon such diagnosis, I authorize Dr. Pappas to perform all recommended treatment on which we mutually agree. I agree to the use of anesthetics, sedatives and other medication as necessary, and I fully understand the risks that may be associated. I know that I can ask for a complete recital of any possible complications. I consent to disclose my oral, written, or electronic health records for the purpose of carrying out my treatment and payment. I have read and understand the privacy policy of this office as stated in writing and/or on the website: www.copleysmiles.com. I agree to be responsible for payment of all services rendered to me or my dependants. If required, I understand a check of my credit history may be made.

Patient Signature: _____ Date: _____

Parent/Responsible Party's Signature: _____ Relationship to Patient: _____