McGILLICUDDY | HUYETT
DENTAL

HEALTH HISTORY

Date:________________

Name ____
Last First Middle Initial

Address ____
Number/Street City State Zip

Phone ________________ ________________ ________________
Home Business Business Name/Occupation

________________ ________________ Marital Status________
Cell E-mail

Date of Birth________________ Age________________ Sex________________

Physician ____
Name Address Phone

Dentist________________________ Referred by________________________

MEDICAL QUESTIONNAIRE

Fill out the following to the best of your knowledge.

DO YOU HAVE OR HAVE YOU HAD: Circle: Yes, No, DK (Don't know)

1. Cardiovascular disease	Yes	No	DK
2. Heart trouble	Yes	No	DK
3. Heart murmur	Yes	No	DK
4. High blood pressure	Yes	No	DK
5. Rheumatic fever	Yes	No	DK
6. Anemia	Yes	No	DK
7. Blood disease	Yes	No	DK
8. Shortness of breath	Yes	No	DK
9. Swelling of ankles	Yes	No	DK
10. Lung disease	Yes	No	DK
11. Tuberculosis	Yes	No	DK
12. Hepatitis	Yes	No	DK
13. Jaundice	Yes	No	DK
14. Liver disease	Yes	No	DK
15. Kidney disease	Yes	No	DK
16. Bladder disease	Yes	No	DK
17. Thyroid disease	Yes	No	DK
18. Diabetes	Yes	No	DK
19. Venereal disease	Yes	No	DK
20. Cancer	Yes	No	DK
21. Cyst, Tumor	Yes	No	DK
22. Epilepsy	Yes	No	DK
23. Seizure disorder	Yes	No	DK
24. Fainting spells	Yes	No	DK
25. Stomach trouble	Yes	No	DK
26. Ulcers	Yes	No	DK
27. Psychiatric treatment	Yes	No	DK
28. Radiation treatment	Yes	No	DK
29. Arthritis, Rheumatoid Arthritis	Yes	No	DK
30. AIDS or AIDS exposure	Yes	No	DK

****
* Pulse *
* Bp / *
* Date *
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____
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OTHER SIDE PLEASE

DO YOU HAVE OR HAVE YOU HAD:

31. Asthma	Yes	No	DK
32. Skin disease, rash	Yes	No	DK
33. Allergy to Penicillin	Yes	No	DK
34. Allergies to ______________________	Yes	No	DK
to ______________________	Yes	No	DK
35. Cortisone treatment in the last 12 months	Yes	No	DK
36. Bruise and Bleed easily	Yes	No	DK
37. Sleep Apnea	Yes	No	DK
38. Do you smoke	Yes	No	DK
39. Do you drink alcohol daily	Yes	No	DK
40. Major illness, operation	Yes	No	DK
41. Currently under physician's care	Yes	No	DK
42. Do you take aspirin regularly	Yes	No	DK
43. Joint(s) Replacement	Yes	No	DK
44. Sleep Apnea and or snoring	Yes	No	DK

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WOMEN ONLY

45. Are you pregnant	Yes	No	DK
46. Take oral contraceptives	Yes	No	DK
47. Have you reached menopause	Yes	No	DK

****

48. List all current medication or drugs __________________ ____________________________
(including Aspirin) __________________ ____________________________

49. Date of your last physical exam ___________________________
by ___________________________

50. ____ ____________________
Patient Signature Date

____
Thomas F. McGillicuddy, D.M.D.
Megan M. Huyett, D.M.D.

****

INSURANCE INFORMATION

50. DENTAL INSURANCE ____
a) Subscriber Name ____
b) Name of Employer ____
c) Subscriber I.D. or
Social Security # ____
d) Group # ____

51. I AUTHORIZE PAYMENT OF DENTAL BENEFITS TO DR. THOMAS F. MCGILLICUDDY, D.M.D.

____
Patient Signature

McGILLICUDDY | HUYETT
DENTAL

THOMAS F. McGILLICUDDY, D.M.D.
MEGAN M. HUYETT, D.M.D.
15 OAK STREET, SUITE 2
NEEDHAM, MASSACHUSETTS 02492-2515

TELEPHONE: (781)444-3853

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse to Sign This Acknowledgement**

I,____________________________, have received a copy of this office's Notice of Privacy Practices.

____
[Please Print Name]

____
[Signature]

____
[Date]

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individuals refused to sign

__ Communication barriers prohibited obtaining this acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

__ Other (Please Specify)

____

____

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INFORMED CONSENT FOR GENERAL PERIODONTAL DENTAL PROCEDURE

You, the patient, have the rights to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated and commonly known risks of the recommended procedures, alternatives treatments, or the option of no treatment.

By consenting to the treatment, you are acknowledging your willingness to accept known risk and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medications, pre and post treatment instructions, referrals to other dentists or specialist, and return for your scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

1. Treatment to be Provided.

I understand that during my courses of treatment that the following care may be provided:

- Examinations
- Radiographs (x-rays)
- Preventive Services
- Periodontal Scaling and Treatment

2. Drugs and Medications

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction)

3. Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while providing care that were not discovered during examination. I give my permission to the dentist to make any changes and additions as necessary. Patient Initials_________

4. I give my permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. Patient Initials_________

___________________________________ ______________

Patient Signature and/or Parent/Guardian Date

___________________________________ _________ This consent will cover my dependents (under age 18) at this office

Please Print Name