

Marina Bay Dental Associates P.C.
308 Victory Road • Quincy, MA 02171

Patient Name: _____

Last

First

Date of Birth

Physician's Name: _____

Physician's Address: _____

Physician's Phone #: _____

Are you under a physician's care? (Other than yearly checkups) Yes No **if yes, When?**

Why?

1. In what year was your last physical exam? **19** , **20** **don't remember**
2. Are you taking any medications or substances? Yes No **if yes, explain:**
3. Are you allergic to any medications or substances? Yes No **if yes, explain:**
4. Do you have any other allergies? Yes No
5. Do you have any problems with penicillin, antibiotics, anesthetics, etc.? Yes No **if yes, explain:**
6. Are you sensitive to any metals or latex? Yes No
7. Are you pregnant or suspect you may be? Yes No
8. Do you use birth control medication? Yes No
9. Have you been treated for or have been told you have heart disease? Yes No
10. Do you have a pacemaker or an artificial heart valve implant? Yes No
11. Any history of rheumatic fever or heart murmurs? Yes No
12. Have you ever had a serious illness or major surgery? Yes No **if yes, explain:**
13. Have you ever had radiation or chemo treatment for tumor, growth, etc? Yes No
14. Do you have inflammatory disease such as arthritis or rheumatism? Yes No
15. Do you have any artificial joints or prosthesis? Yes No
16. Do you have any blood disorder such as anemia, leukemia, etc? Yes No
17. Have you ever bled excessively after being cut or injured? Yes No
18. Do you have any stomach, kidney or liver problems? Yes No
19. Are you diabetic? Yes No
20. Do you have asthma? Yes No
21. Do you have epilepsy or seizure disorders? Yes No
22. Have you tested positive for HIV? Yes No
23. Do you have AIDS? Yes No
24. Have you have or had tested positive for Hepatitis? Yes No
25. Do you have or had T.B.? Yes No
26. Do you smoke, chew, use snuff or any other form of tobacco? Yes No **if yes, how often:**
27. Do you consume alcoholic beverages? Yes No
28. Have you had psychiatric treatment? Yes No **if yes, explain:**
29. Do you have any disease, condition, or problem not listed? Yes No **if yes, explain:**
30. Is there anything else we should know about your health? Yes No **if yes, explain:**

I Certify that the above information is Complete and Accurate

Patient/Guardian Signature: _____ Date _____

Dentist Signature: _____ Date _____