PATIENT IDENTIFICATION AREA

BRIGHAM AND WOMEN'S HOSPITAL
75 Francis Street, Boston, MA 02115

Bar code

Division of Oral Medicine and Dentistry
New Patient Intake Form

Patient Name: _____DOB: _____

Referring doctor: _____

Address: _____

Phone number: _____

Primary Care Provider: _____

Address: _____

Phone number: _____

Primary Dentist: _____

Address: _____

Phone number: _____

Pharmacy Name:_____

Address: _____

Phone number: _____

Reason for today's visit: _____

_____

_____

_____

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New Patient In-Take Form

Please provide contact information for other doctors or specialists (examples: dermatologist, ear nose & throat (ENT) surgeon, oral surgeon, periodontist, psychiatrist, rheumatologist) whom you have seen for this condition.

Name of Specialist	Specialty	Address	Phone Number

Please circle YES or NO to the following questions; include a brief explanation if necessary.

YES NO Do you consider yourself to be in good health?_____

YES NO Have there been any big changes to your general health in the past year?

_____

YES NO Are you now under the care of a physician for any condition(s)?_____

_____

YES NO Have you ever had a serious illness or operation?_____

_____

_____

YES NO Have you fallen down within the past year?_____

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Division of Oral Medicine and Dentistry:
New Patient In-Take Form

Please check any of the following conditions you currently have or have had previously:

	Appetite changes		Depression		HIV/AIDS		Seizures
	Artificial heart valve		Diabetes/high blood sugar		Hoarseness		Sexually transmitted diseases
	Artificial joints		Difficulty breathing		Itchiness		Sinus infections
	Asthma		Difficulty swallowing		Joint swellings		Skin lesions
	Bleeding problems		Dizziness		Kidney disease		Spasms
	Blood in urine		Easy bruising		Lung disease		Stroke
	Bloody stools		Emphysema		Muscle/joint pain		Swollen lymph nodes
	Cancer		Fainting		Nausea		Thyroid problems
	Change in bowel movements		Fatigue		Night sweats		Tuberculosis
	Change in frequency of urination		Frequent nosebleeds		Problems with heat or cold		Vision problems
	Chest pain		Headaches		Psychiatric therapy		Vomiting
	Constipation		Heart attack		Rashes		Weakness
	Cough		High blood pressure		Rheumatic fever		Weight changes

Please list all prescription and over-the-counter medications you take:

Medication name	How do you take this? (for example: by mouth)	Medication name	How do you take this? (for example: by mouth)

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Are you allergic or sensitive to any of the following?

Allergy	YES/NO	Reaction (What happens?)
Local anesthetics (including "Novocaine")		
Antibiotics (including penicillin, erythromycin)		
Sulfa drugs		
Pain medications (including aspirin, codeine, other narcotics)		
Sedatives or tranquilizers		
Iodine		
Latex		
Metals (including nickel, gold, silver)		
Other medications, food, or materials		

YES NO Do you smoke cigarettes? If so, how many packs/day? _____

For how many years? _____

YES NO Have you ever smoked cigarettes? _____

How many packs/day? _____

For how many years? _____

YES NO Do you drink alcohol? If so, how much per day or week? _____

YES NO Do you use or have you used recreational drugs (marijuana, cocaine, ectasy, etc)?

YES NO Have you been in a relationship in which you were threatened or physically hurt?

YES NO Are you married?

YES NO Do you have children?

YES NO (Women only) Are you pregnant or nursing?

YES NO (Women only) Are you taking birth control pills?

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YES NO (Women only) Have you ever experienced Post Partum Depression?

YES NO Do you work? _____

YES NO Do you have any other disease, condition, or problem not already listed about which your doctor should know? Please specify: _____

_____

_____

YES NO Did you receive/review the pamphlet titled "We Care About Your Safety?"

YES NO Do you have a Health Care Proxy?_____

Was your most recent dental visit for routine care or emergency? _____

Date of most recent full mouth series of X-rays: _____

YES NO Do you experience chronic tooth or mouth pain?_____

YES NO Have you ever had trouble or problems with dental treatment?_____

How do you like to learn? ❒ Talking with your nurse or doctor ❒ Reading ❒ Video (if available)

The information on this form is accurate to the best of my knowledge. I understand that this form will become part of my medical record.

Patient Signature: _____Date: _____

I have reviewed the above information with the patient including review of the patient's medications.

Comments:_____

Signature _____ DMD/DDS CID☐☐☐☐☐

Date:_____Time:_____ AM/PM