Comprehensive Dental Solutions of Boston
GEORGE MARYNIUK, DDS, MPH
PROSTHODONTIST

PERSONAL

Date: _____

Name: _____ Occupation: _____

Address: _____

_____ ____, _____

Date of Birth: _____ SS#: _____ E-Mail: _____

Home: (____) _____ Cell: (____) _____ Work: (____) _____

Emergency Contact: _____ (relationship) _____ Phone: _____

If you have dental insurance, please present your card with this form.

MEDICAL

Physician: _____ Phone: _____ Last exam: _____

1. Are you under medical treatment presently? If so, explain _____
_____

2. Have you been hospitalized for any surgical operation or serious illness in the past five years?
reason: _____

3. Are you taking any medications including over the counter or prescription medicines?
List them here:

_____ _____ _____
_____ _____ _____

4. Are you allergic to or have you had any reactions to any drugs? If yes, please specify?
_____
_____

5. Do you require pre-medication before dental appointments? If so, explain:
_____

6. Please indicate which of the following applies to you. Check only if answer is yes.

__ High Blood Pressure
__ Cardiovascular Disease (heart attack, angina, stroke)
__ Cardiac Pacemaker
__ Damaged or artificial heart valves, including murmur or rheumatic heart disease
__ AIDS/HIV
__ Abnormal bleeding
__ Joint Replacement or implant
__ Anemia
__ Tuberculosis
__ Hepatitis
__ Immune system insufficiency
__ Diabetes

7. Women only:
   * Are you pregnant or think you may be pregnant? Y / N
   * Are you nursing? Y / N
   * Are you taking birth control pills? Y / N

DENTAL

1. Are any of your teeth:
   * Temperature sensitive? Y / N _____
   * Biting sensitive? Y / N _____
   * Painful? Y / N _____
   * Chipped and or worn down? Y / N _____

2. Do you have any sores or lumps in or near your mouth? Y / N

_____

3. Do you experience any of the following with your jaw?
__ pain
__ popping, clicking
__ difficulty opening and closing
__ difficulty chewing

4. The color of my teeth are: [Light] [Average] [Dark]

5. How do you feel about your teeth?

_____

_____

6. How do you feel about your smile?

_____

_____

7. If you had a magic wand, what would you change about your smile or the rest of your teeth?

_____

_____

_____

_____ _____
Signature of Patient Date

_____ _____
Signature of Dentist Date