PATIENT NAME

PATIENT NAME _____ TODAY'S DATE _____

HOME ADDRESS _____ DATE OF BIRTH _____

_____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

_____ SS #/SIN _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____		
4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	☐	☐
5. DO YOU USE TOBACCO?	☐	☐
6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	☐	☐
7. ARE YOU WEARING CONTACT LENSES?	☐	☐

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	LOCAL ANESTHETICS (EG. NOVOCAINE)	☐	☐	BARBITURATES	☐	☐	ASPIRIN
☐	☐	PENICILLIN OR OTHER ANTIBIOTICS	☐	☐	SEDATIVES	☐	☐	OTHER _____
☐	☐	SULFA DRUGS	☐	☐	IODINE			_____

	YES	NO
9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?	☐	☐
10. WOMEN ONLY:		
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	HEART DISEASE	☐	☐	CHEST PAINS
☐	☐	HEART ATTACK	☐	☐	CARDIAC PACEMAKER	☐	☐	EASILY WINDED
☐	☐	RHEUMATIC FEVER	☐	☐	HEART MURMUR	☐	☐	STROKE
☐	☐	SWOLLEN ANKLES	☐	☐	ANGINA	☐	☐	HAY FEVER / ALLERGIES
☐	☐	FAINTING / SEIZURES	☐	☐	FREQUENTLY TIRED	☐	☐	TUBERCULOSIS
☐	☐	ASTHMA	☐	☐	ANEMIA	☐	☐	RADIATION THERAPY
☐	☐	LOW BLOOD PRESSURE	☐	☐	EMPHYSEMA	☐	☐	GLAUCOMA
☐	☐	EPILEPSY / CONVULSIONS	☐	☐	CANCER	☐	☐	RECENT WEIGHT LOSS
☐	☐	LEUKEMIA	☐	☐	ARTHRITIS	☐	☐	LIVER DISEASE
☐	☐	DIABETES	☐	☐	JOINT REPLACEMENT OR IMPLANT	☐	☐	HEART TROUBLE
☐	☐	KIDNEY DISEASES	☐	☐	HEPATITIS / JAUNDICE	☐	☐	RESPIRATORY PROBLEMS
☐	☐	AIDS OR HIV INFECTION	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐	OTHER _____
☐	☐	THYROID PROBLEM	☐	☐	STOMACH TROUBLES / ULCERS			_____

COMMENTS

_____

_____

_____

_____

_____

SIGNATURE OF DENTIST DATE

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
A) CLICKING?	☐	☐
B) PAIN (JOINT, EAR, SIDE OF FACE)?	☐	☐
C) DIFFICULTY IN OPENING OR CLOSING?	☐	☐
D) DIFFICULTY IN CHEWING?	☐	☐

	YES	NO
8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
12. HAVE YOU HAD ANY ORTHODONTIC WORK?	☐	☐
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	☐	☐
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	☐	☐

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X _____ _____

PATIENT, PARENT OR GUARDIAN DATE

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

SIGNATURE

X _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

NEW PATIENT QUESTIONNAIRE:

Patient Name: _____

1. **What have your previous experiences with dentistry been like?**

2. **What have you liked or disliked about your previous dentist?**

3. **Did your parents have problems with their teeth? Are you following the same pattern?**

4. **Do you like your smile? Is there anything you would like to change about *your smile*?**

5. **Do you want to keep your teeth forever?**

6. **What role does your insurance play with your dental health?**

7. **Please rate the following in order of importance from 1 to 4, with 1 being the most important.**
   - **Health**
   - **Cost**
   - **Appearance**
   - **Function**

8. **Who may we thank for referring you to our office?**

WILLIAM C. LUND D.M.D.
CARA A. LUND D.M.D.
2 MAIN STREET, SUITE 225
STONEHAM, MA 02180

PATIENT AUTHORIZATION FORM

I hereby authorize the above named dentists to use or disclose specific information described below, only for the purposes and parties also described below.

- Notify you of future appointments by the way of postcard, and or email.
- Confirm appointments leaving messages on your home answering machine, voice mail at work, or with the person who may answer the phone numbers you have provided us with.
- Utilize the information provided to us for purposes of billing and to obtain payment from an insurance company for payment.

I acknowledge that I was provided a copy of the Notice of Privacy Practices, and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative

_____
Signature

William C. Lund D.M.D.
Cara A. Lund D.M.D.
2 Main Street, Suite 225
Stoneham, MA 02180

Patient Name: _____

Listed below are our office disclaimers. Two of the four address insurance issues, if you do not have insurance coverage than please skip to disclaimer 4, and just sign that. If you do have insurance we need you to ac knowledge all of the disclaimers.

1. I understand that my insurance is an agreement between me an my insurance Company. I also understand that I am responsible for my balance regardless of insurance coverage.

2. I assign dental benefit payments to be paid directly to Dr. William Lund, and Dr. Cara Lund from my insurance company.

Patient or Parent/Guardian Signature Date

3. I give permission for Dr. William Lund, Dr. Cara Lund, and their clinical team to take any necessary x-rays, photos, or study models to enable complete diagnosis and treatment.

4. I understand that my account may be charge 1.5% per month or 18% per year Finance charge if any balance goes beyond 90 days.

Patient or Parent/Guardian Signature Date