Wellesley Hills Dental
Hanna Q. Cao, DDS
332 Washington Street, Suite 330
Wellesley, MA 02481

New Patient Intake Form

Name: _____
First Last MI
Preferred Name: _____
Address: _____ City: _____ State: _____ Zip: _____
SSN: _____ DOB: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email Address: _____
Employer: _____ Occupation: _____
Marital Status: _____
How did you hear about us? _____
Do you prefer to be contacted via e-mail or phone? _____

Insurance – Primary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____
Subscriber SSN/ID: _____ Subscriber Employer: _____
Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Phone: _____ Group Number: _____

Insurance – Secondary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____
Subscriber SSN/ID: _____ Subscriber Employer: _____
Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Phone: _____ Group Number: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Wellesley Hills Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____
Relationship: _____ Date: _____

Consent: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____

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Medical History

Physician Name: _____ Physician Phone: _____
Date of last visit: _____ Are you currently being treated for any condition? (please list): _____
Do you use tobacco in any form? (please list): _____
Do you have any metal rods, pins or implants placed? (please list): _____
Please list any medications you're taking: _____
Please list any surgical procedures you've had: _____

Please Circle Conditions You Have

Abnormal Bleeding	Y	N	Facial Surgery	Y	N	Mitral Valve Prolapse	Y	N
Alcohol Abuse	Y	N	Fainting Spells	Y	N	Pace Maker	Y	N
Allergies	Y	N	Fever Blisters	Y	N	Psychiatric Problems	Y	N
Anemia	Y	N	Frequent Headaches	Y	N	Radiation Therapy	Y	N
Angina/Chest Pain	Y	N	Glaucoma	Y	N	Rheumatic Fever	Y	N
Arthritis	Y	N	HIV / AIDS	Y	N	Seizures	Y	N
Artificial Heart Valve	Y	N	Heart Attack	Y	N	STDs	Y	N
Asthma	Y	N	Heart Murmur	Y	N	Shingles	Y	N
Blood Transfusion	Y	N	Heart Surgery	Y	N	Sickle Cell Disease	Y	N
Cancer	Y	N	Hemophilia	Y	N	Sinus Problems	Y	N
Chemotherapy	Y	N	Hepatitis A	Y	N	Stroke	Y	N
Colitis	Y	N	Hepatitis B	Y	N	Thyroid Problems	Y	N
Congenital Heart Defect	Y	N	Hepatitis C	Y	N	Tuberculosis	Y	N
Diabetes	Y	N	High Blood Pressure	Y	N	Ulcers	Y	N
Difficulty Breathing	Y	N	Joint Replacement	Y	N	Other (Please List):		
Drug Abuse	Y	N	Kidney Problems	Y	N			
Emphysema	Y	N	Liver Disease	Y	N			
Epilepsy	Y	N	Low Blood Pressure	Y	N			

Allergies

Aspirin	Y	N
Codeine	Y	N
Dental Anesthetics	Y	N
Erythromycin	Y	N
Latex	Y	N
Metals	Y	N
Penicillin	Y	N
Sulfa Drugs	Y	N
Tetracycline	Y	N

Other Allergies (please list):

If Female, Please Answer

Are you taking birth control?	Y	N
Are you pregnant?	Y	N
If so, # of Weeks: _____		
Are you nursing?	Y	N

Emergency Contact Person (not living with you):
Name: _____ Relationship: _____
Address: _____ Phone: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

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Dental History

How may we help you today? _____

Your current dental health is: Good Fair Poor

Do you require antibiotics before dental treatment?	Y	N
Are you currently in pain?	Y	N
Have you ever had gum treatment?	Y	N
Do you now or have you had any pain / discomfort in your jaw joint? (TMJ)	Y	N
Do you like your smile?	Y	N
Is there anything you would like to change your smile?	Y	N
Are you happy with the color of your teeth?	Y	N
Do your gums bleed?	Y	N
How many times do you floss/week? _____ Brush/day? _____		
Are your teeth sensitive to heat, cold or anything else?	Y	N
Have you lost any teeth?	Y	N
Have you ever had a serious/difficult problem with any previous dental work?	Y	N
Have you ever had any unfavorable dental experience?	Y	N

When was your last dental cleaning? _____
When was your last dental visit? _____
Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

We offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening	Veneers	Invisalign
Smile Makeover	Bonding	Implant Crowns
Sealants	Crown and Bridge	
Dentures	Night Guards / Sport Guards	