SHARRI L. TRILLING, D.M.D.
1093 NORTH MAIN STREET
RANDOLPH, MASSACHUSETTS 02368

Patient's Name______________________________ Sex: M F Birthdate____________ Age ________ Today's Date______________

Home Address____ City____________________ State_______ Zip __________

Previous Address (if less than 3 Years)____________________________ City____________________ State_______ Zip __________

Please Circle One: Single, Married, Separated, Divorced, Widowed Occupation______________ Home Phone Number______________

Your Employer____________________ How Long Employed?____ Your Soc. Sec. #________________ Work Phone ______________

Are you a full time student? ☐ Yes ☐ No If Patient is a minor we need: Mother's Birthdate__________ Father's Birthdate__________

Name of Spouse (Parent if Minor)____________________________ Person Responsible for Account ______________________

Spouse's (Parents') Employer____________________ Spouse's Soc. Sec. #________________ Work Phone ______________

Referred to us by ______________________________ EMERGENCY INFORMATION ______________________

Reason for this visit ______________________________ Name, Address & Telephone of a Relative Not living with you ______________________

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name ______________________________

Insurance Co. ______________________________

Insurance Co. Address ______________________________

Insured's Employer ______________________________

Insured's Soc. Sec. #__________________ Group #:______ Local #______

If you have double dental insurance complete this for the second coverage.

Insured's Name ______________________________

Insurance Co. ______________________________

Insurance Co. Address ______________________________

Insured's Employer ______________________________

Insured's Soc. Sec. #__________________ Group #:______ Local #______

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionaire

* DENTAL HISTORY *

	YES	NO
How LONG SINCE you have seen a Dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE: *(Machine that rotates around you head, or 16 small films.)*		
Are you having PROBLEMS now?	☐	☐
WHAT?	☐	☐
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Have you had BAD dental experiences in the past?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PROFESSIONAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Do you have problems with teeth/fillings BREAKING?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐
Would you like us to help you learn proper methods of Home Care, so you can stop dental problems in your mouth?	☐	☐

Name of Previous Dentist:

City: State:

How do you feel about your teeth?

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.

FEAR of pain # LACK of concern #

COST of treatment # MISSING work time #

* MEDICAL HISTORY *

	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For What?		
Are you currently taking any medication?	☐	☐
If Yes, what?		

Circle any of the following which you have had or have at present:

Heart Failure	A.I.D.S.	Bruise Easily
Heart Disease or Attack	Hepatitis A (infectious)	Emphysema
Angina Pectoris	Hepatitis B (serum)	Tuberculosis (TB)
High Blood Pressure	Liver Disease	Asthma
Heart Murmur	Yellow Jaundice	Hay Fever
Rheumatic Fever	Blood Transfusion	Sinus Trouble
Congenital Heart Lesions	Drug Addiction	Allergies or Hives
Scarlet Fever	Hemophilia	Diabetes
Artificial Heart Valve	Fever Blisters	Thyroid Disease
Heart Pacemaker	Epilepsy or Seizures	X-ray or Cobalt Treatment
Heart Surgery	Fainting or Dizzy Spells	Arthritis
Artificial Joints (Hip, Knee)	Nervousness	Rheumatism
Anemia	Psychiatric Treatment	Cortisone Medicine
Stroke	Sickle Cell Disease	Pain in Jaw Joints
Kidney Trouble	Glaucoma	
Ulcers	Chemotherapy (Cancer, Leukemia)	
Cosmetic Surgery	Venereal Disease (Syphilis, Gonorrhea, etc.)	

Are you allergic or have you reacted adversely to any of the following medications?

Aspirin	Percodan	Erythromycin
Darvon	Local Anesthetic	Valium
Nitrous Oxide	Codeine	Penicillin

Are you aware of being allergic to any other medications or substances?

If yes, pleast list: ______________________________

FAMILY PHYSICIAN:______________________ PHONE NO.__________

Is there any other Medical or Dental information that you feel I should know about?

____

____

____

FORM 053989 N/07/00 ITEM 8101 COLWELL SYSTEMS 1.800.637.1140