John T. Veale D.M.D., M.P.H.
Peter G. Veale D.M.D.
448 Turnpike St. S. Easton, MA 02375
45 Slocum Rd. Dartmouth, MA 02747

Patient Information

Name: (*First*) _____ (*Last*) _____ (*Middle Initial*) _____ (*Preferred Name*) _____

Address: (*Street*) _____

(*City*) _____ (*State*) _____ (*Zip*) _____

Date of Birth _____ □ Male □ Female

Phone: Home (____) _____ □ □ Single □ Married □ Divorced □ Widowed

Work (____) _____ □ Social Security # _____

Cell (____) _____ □ Email: _____

Please check primary contact phone number.

How did you hear about us? □ Yellow Pages □ Internet □ Walk in □ Insurance
□ Patient Referral _____ □ Other _____

Are you currently a full time college student? □ Y □ N * If yes, name of college _____

Primary Dental Insurance

Subscriber Name _____ SS # / Subscriber # _____ D.O.B _____
Insurance Co. _____ Insurance Co. Phone # _____
Employer _____ Relation to Patient _____

Secondary Dental Insurance

Subscriber Name _____ Subscriber ID # _____ D.O.B _____
Insurance Co. _____ Insurance Co. Phone # _____
Employer _____ Relation to Patient _____

Dental History (*Please indicate if you have had any of the following*)

Reason for today's visit _____ Date of last dental visit _____

□ Bad breath
□ Bleeding gums
□ Blisters on lips or mouth
□ Burning sensation on tongue
□ Chew on one side of mouth
□ Cigarette, pipe, or cigar smoking
□ Clicking or popping jaw
□ Dry mouth
□ Fingernail biting
□ Food collection
□ Grinding teeth
□ Gums swollen / tender
□ Jaw pain or tiredness
□ Lip or cheek biting
□ Loose teeth/fillings
□ Mouth breathing
□ Orthodontic treatment
□ Pain around ear
□ Periodontal treatment
□ Sensitivity cold or hot
□ Sensitivity sweets or biting
□ Sores or growths in mouth
□ How often do you floss _____
□ How often do you brush _____

The information on this page is correct to the best of my knowledge.

Signature _____ **Print** _____ **Date** _____

If Patient is a child: *Parent or Guardian Signature* _____ Print Name _____ Date _____

John T. Veale D.M.D., M.P.H.
Peter G. Veale D.M.D.

Name _____ **Date of Birth** _____ **SS #** _____ **Date**_____

Primary Care Physician's Name _____ Physician's Phone # _____

****Please list any medications you are currently taking** (*note: if you have a written list we can take a photo copy)*

_____

Has a physician advised you an antibiotic premedication is needed for dental treatment? □ **Y** □ **N** If yes which RX? _____

Have you had a serious illness or operation? □ **Y** □ **N** If yes, please describe_____

Are you currently under physicians care? □ **Y** □ **N** If yes, please describe_____

Occupation: _____

Emergency Contact: Name_____ Relation_____ Phone _____

Medical History and Information (***Please indicate if you have had any of the following***)

Do you smoke / use tobacco? □ **Y** □ **N**
Are you taking birth control? □ **Y** □ **N**
Are you pregnant? □ **Y** □ **N**
Are you nursing? □ **Y** □ **N**

ALLERGIES

□ Aspirin
□ Barbiturates (Sleeping Pills)
□ Codeine
□ Dental Anesthetics
□ Erythromycin
□ Iodine
□ Latex
□ Metals
□ Penicillin
□ Seasonal Allergies
□ Sulfa
□ Tetracycline
□ Other Allergies _____

CONDITIONS

□ Abnormal Bleeding
□ Alcohol Abuse
□ Anemia
□ Angina Pectoris
□ Arthritis
□ **Artificial Heart Valve**
□ Asthma
□ Back Problems
□ Blood Disease
□ Blood Transfusion
□ Cancer
□ Chemotherapy
□ Circulatory Problems
□ Colitis
□ Congenital Heart Defect
□ Cortisone Treatments
□ Cough Persistent or Bloody
□ Diabetes
□ Difficulty Breathing
□ Drug Abuse
□ Emphysema
□ Epilepsy
□ Facial Surgery
□ Fainting or Dizzy
□ Fever Blisters
□ Glaucoma
□ Headaches
□ **Heart Attack**
□ **Heart Murmur**
□ **Heart Problems**
□ **Heart Surgery**
□ Hemophilia
□ Hepatitis A
□ Hepatitis B
□ Hepatitis C
□ Herpes
□ High Blood Pressure
□ HIV / Aids
□ Jaundice
□ Jaw Pain
□ **Joint Replacement**
□ Kidney Problems
□ Liver Disease
□ Low Blood Pressure
□ **Mitral Valve**
□ Nervous Problems
□ Pace Maker
□ Psychiatric Care
□ Radiation Treatment
□ Respiratory Disease
□ **Rheumatic Fever**
□ **Scarlet Fever**
□ Seizures
□ Sexually Transmitted Diseas
□ Shingles
□ Shortness of Breath
□ Sickle Cell Disease
□ Sinus Problems
□ Skin Rash
□ Special Diet
□ Stroke
□ Swollen Feet/Ankles
□ Swollen Neck Glands
□ Thyroid Problems
□ Tonsillitis
□ Tuberculosis
□ Tumor/Growth on Head/Ne
□ Ulcers
□ Other Conditions? _____

Treatment Authorization Form

The information on this page is correct to the best of my knowledge. I authorize and give consent to perform dental service agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesi and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

Signature_____**PrintName**_____**Date**_____