FREDERICK J. NORFOLK, DMD 116 WATER ST. MILFORD, MA 01757 508-478-7925

PATIENT INFORMATION

Mr. Mrs. Ms. Dr.

Last_____ First_____ MI_____ DOB___/___/____ SS#_____

☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address _____
Town State Zip

Home (____) - ____ - _____ Cell (____) - ____ - _____ Work (____) - ____ - _____

Occupation _____ Employer _____ Town_____Zip_____

Person Financially Responsible _____ Relationship_____

Billing Address _____
(Leave blank if same as above) Town State Zip

In case of emergency, who is the nearest relative not living with you?
Name_____ Home (___)-_____-_____ Cell (___)-____-_____ Work (___)-____-_____

Who may we thank for referring you?_____

MEDICAL HISTORY

Are you in good health? ☐ Yes ☐ No *if no, please explain*_____

Are you currently taking any medication? ☐ Yes ☐ No *if yes, please list:*

_____

Have you been hospitalized in the last two years? ☐ Yes ☐ No *if yes, please explain*_____

Do you smoke? ☐ Yes ☐ No *if yes, what?* _____ *How much?*_____

Date of last physical examination:_____Name and Location of Physician: _____

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other_____

Do you currently have or have you ever had, any of the following?

☐ Heart Disease	☐ Shortness of Breath	☐ Substance/ Alcohol Abuse
☐ High Blood Pressure	☐ Currently Pregnant	☐ Recreational Drug Use
☐ Blood Disease	☐ Fainting Spells	☐ Artificial Heart Valve
☐ Rheumatic Fever	☐ Thyroid Problems	☐ Artificial Joints
☐ Heart Murmur	☐ Anemia	☐ Birth Control
☐ Mitral Valve Prolapse	☐ Radiation Treatment	☐ Bruise/Bleed Excessively
☐ Heart Pace Maker	☐ Liver Disease	☐ HIV/AIDS
☐ Diabetes	☐ Kidney Disease	☐ Arthritis
☐ Stroke	☐ Hepatitis, Jaundice	☐ Tumor/Cancer

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____