PATIENT INFORMATION

Date ____________________

NAME ______________________________________ Married ___ Single___ Partnered___ Male___ Female___

ADDRESS ____

CITY _______________________________________ STATE ________________ ZIP CODE ________________

PHONE (Home) _____________________________ (Work) ____

PHONE (Cell) _______________________________ E-mail ____

BIRTH DATE ________________________________ SS# ____

IF FULL TIME COLLEGE STUDENT, SCHOOL NAME ____

SPOUSE OR PARENT'S NAME ____

PATIENT'S OR PARENT'S EMPLOYER ____

DENTAL INSURANCE COMPANY ______________________________ GROUP # ______________________________

NAME OF SUBSCRIBER ____

SUBSCRIBER SS# ____________________________________ SUBSCRIBER DOB ___________________________

Has any member of your family ever been treated in our office? ____

Whom may we thank for referring you to our office? ____

Person to contact in case of emergency _________________________________ Phone __________________________

MEDICAL HISTORY

Do you see a physician regularly? Yes_____ No _____ If so, why? ____

Physician name __________________________ Office phone ____________________ Date of last exam ____________________

Have you ever been hospitalized or had a major operation? Yes ___ No ___ Discuss ___________________________________

Have you ever had a serious injury to your head, neck or mouth? Yes ___ No ___ Discuss _____________________________

***** Have you ever been treated for osteoporosis or osteopenia? Yes (currently) ____ Yes (in the past) ____ No ____**

***** If yes, are you presently taking or have ever taken a bisphosphonate or any medication for osteoporosis or osteopenia?**

> **Ex: Fosamax (*alendronate*), Fosamax Plus D (*alendronate/cholecalciferol*), Zometa (*zolendronic acid*), Didronel (*etidronate*), Reclast (*zolendrolic acid*), Boniva (*ibandronate*), Actonel (*risedronate*), Aclasta (*zolendronic acid*), Aredia (*pamidronate*), Atelvia (*risedronate*), Skelid (*tiludronate*), Prolia (*denosumab*)**

Please explain and/or list which medication:

____

Please list all <u>MEDICATIONS</u> including prescription, over-the-counter, herbal or holistic remedies, vitamins or minerals:

____

*****Are you allergic to any medications or substances? Yes____ No ___Please circle:**

Codeine/other painkillers **Sulfa Drugs** **Food** **Fluoride** **Aspirin/Ibuprofen**

Penicillin/other antibiotics **Acrylic** **Latex rubber** **Nitrous oxide**

Sedatives/Barbituates **Metals (gold, stainless steel, nickel)** **Local Anesthesia (novocaine, etc.)**

Alcohol **Other ___________________________**

WOMAN (PLEASE CHECK)

Pregnant/trying to get pregnant _________________ Nursing ______________ Oral Contraceptives___________

Are you on hormone replacement therapy? Yes ____ No ____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

The ** questions may require premedication for treatment.

	Y	N		Y	N		Y	N		Y	N
Scarlet Fever**			High Blood Pressure			Mental Health Care			Epilepsy/Seizures		
Heart Murmur**			Low Blood Pressure			Ulcers/Acid Reflux			Fainting/Dizziness		
Rheumatic Fever**			Asthma/Hay Fever			Stomach/Intestinal Disease			Hepatitis B, C (Serum)		
Artificial Heart Valve**			Sinus Problems			Loss of Hearing			Hepatitis A (Infectious)		
Heart Pacemaker**			Excessive Bleeding			Eye Impairments			Yellow Jaundice		
Heart Surgery**			Hemophilia			Glaucoma			Liver Disease		
Mitral Valve Prolapse**			Bruise Easily			Headaches			Kidney Disease		
Artificial Joint**			Blood Transfusion			Marked Weight Change			Renal Dialysis		
Rx Diet Drugs**			Anemia			Hypoglycemia			Thyroid Disease		
Radiation Therapy**			Leukemia			Arthritis/Gout			Lyme Disease		
Chemotherapy**			Irregular Heart Beat			Tumors/Growths			Cortisone Medication		
Diabetes**			Angina/Chest Pain			Emphysema			AIDS/HIV Positive		
Congenital Heart Disorder			Stroke			Difficulty Breathing			Sexually Transmitted DIseases		
Heart Attack/Failure			Cancer			Tuberculosis			Drug Addiction		

Do you have any disease, condition, or problem not listed above that you think we should know about? Yes____ No ____

If yes, please explain:____

DENTAL HISTORY

Date of last dental visit _________________ **Date of last full mouth x-rays (20 x-rays or Panoramic)** _______________

Name of your previous dentist ______________________________ **City, State** ___________________________________

Do you have a specific dental problem? Yes____ No____

How long has it been present? ____

Does dental treatment make you nervous? No____ Slightly____ Moderately____ Extremely ____

Do you snore or have sleep apnea? Yes____ No____

Have you ever been tested for sleep apnea? Yes____No____ Do you wake feeling rested in the morning? Yes____ No____

	Y	N		Y	N
Do your gums bleed while brushing or flossing?			**Do you have frequent headaches?**		
Are your teeth sensitive to hot or cold liquids/foods?			**Do you clench or grind your teeth?**		
Are your teeth sensitive to sweet or sour liquids/foods?			**Do you bite your lips or cheeks frequently?**		
Do you feel pain to any of your teeth?			**Have you ever had any difficult extractions in the past?**		
Do you have any sores or lumps in or near your mouth?			**Have you ever had any prolonged bleeding following extractions?**		
Have you had any head, neck or jaw injuries?			**Do you wear a night guard or retainer?**		
Do you have difficulty in opening, closing, or moving your jaw?			**Have you had any orthodontic treatment?**		
Clicking, popping or difficulty chewing?			**Do you wear dentures or partials?**		
Pain, tenderness, numbness in your jaw?			**Have you ever received oral hygiene instructions regarding the care of your teeth and gums?**		

Have you ever had serious trouble associated with previous dental treatment?

____

Have you whitened/bleached your teeth? Yes_____ No_____

Do you use tobacco in any form? No _____ If yes, how much ____

How long____

Did you use tobacco in the past? No_____ If yes, how much ____

How long ____

Do you have a family history of oral cancer? Yes_____ No_____

Do you use candy, mints, or gum throughout the day? Yes_____ No_____

Do you sip soda, juice, coffee or tea throughout the day? Yes_____ No_____

AUTHORIZATION AND RELEASE

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. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf for all my dependents.

X ____

Signature of patient (or parent if minor)

X ____

Signature of doctor/hygienist