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Specialists in Prosthodontics

The following information will make it possible for us to be more successful and thorough in your treatment. Your answers are for our records only and considered confidential.

Personal Information:

Last Name First MI Nickname Date
Home Address: Home Phone: ( )
City: State: Zip Code: Cell Phone:( )
Birthday:_____ Sex: M F E-mail: _____
Referring Dentist:

Dental Insurance Information: *Please note that insurance is filed as a courtesy.*

Carrier Name:_____ Subscriber ID:_____

Emergency Contact Information:

Name: Home/Cell Phone :( )
Relationship to Patient: Work Phone:( )

Medical/Dental History:

Medical Physician's Name: Phone Number:( )
Reason for Last Visit: Date of Last Visit:

Yes__ No__ Are you taking any medicine, drugs or pills of any kind?
_____
_____
__

Yes__ No__ Have you ever taken Bisphosphonates (Fosamax, Boniva, Reclast or Prolia)?_____

Yes__ No__ Have you ever been hospitalized? If yes, please describe when and why:
_____
_____
__

Yes__ No__ Have you ever had an operation or surgery? If yes, please describe when and why:_____
_____
__

Yes__ No__ Have you taken cortisone, prednisone, or other steroids in the past 12 months?

Yes__ No__ Do your ankles swell during the day?

Yes__ No__ Have you unintentionally lost or gained 10 pounds in the last year?

Yes__ No__ Are you on a special diet?

Yes__ No__ Has your occupation ever brought you in contact with blood or needles?

DENTAL HISTORY

Yes__ No__ Do you make regular (non-emergency) visits to the dentist?

Yes__ No__ Do your teeth feel loose?

Yes__ No__ Do your gums bleed when you brush your teeth?

Yes__ No__ Are any of your teeth painful to biting or chewing?

Yes__ No__ Do you ever have pain, clicking, popping or grinding near the ear when opening or closing your mouth?

Yes__ No__ Do you grind or clench your teeth?

Yes__ No__ Does your mouth frequently feel dry?

Yes__ No__ Have you ever worn braces or had false teeth?

Yes__ No__ Have you ever fainted or had a bad experience related to dental treatment?

*** CONTINUED ON BACK ***

Women Only

Yes__ No__ Is there a possibility you may be pregnant?

Yes__ No__ Are you nursing?

Yes__ No__ Are you taking birth control pills?

Have you ever experienced or been diagnosed with (check yes or no):

CARDIOVASCULR

Heart failure	Yes__	No__
Heart disease or attack	Yes__	No__
Angina or chest pain	Yes__	No__
High blood pressure	Yes__	No__
Heart murmur	Yes__	No__
Mitral valve prolapse	Yes__	No__
Rheumatic fever	Yes__	No__
Congenital heart defect	Yes__	No__
Artificial heart valve	Yes__	No__
Irregular heart beat (arrhythmia)	Yes__	No__
Pacemaker or defibrillator	Yes__	No__

HEMATOLOGIC

Blood transfusion	Yes__	No__
Anemia	Yes__	No__
Sickle cell anemia	Yes__	No__
Tendency to bleed longer than normal	Yes__	No__
Hemophilia	Yes__	No__

NEUROLOGICAL

Stroke	Yes__	No__
Glaucoma or cataract	Yes__	No__
Earaches or ringing in ears	Yes__	No__
Severe headaches, migraines	Yes__	No__
Fainting or dizzy spells	Yes__	No__
Epilepsy, seizures, or convulsions	Yes__	No__
Psychiatric treatment	Yes__	No__

ENDOCRINE

Diabetes	Yes__	No__
Thyroid disease	Yes__	No__

DERMAL/ORAL/MUSCULOSKELETAL

Skin rash or hives	Yes__	No__
Arthritis, rheumatism or gout	Yes__	No__
Artificial joint	Yes__	No__
Fever blisters or canker sores	Yes__	No__

GASTROINTESSTINAL

Stomach or intestinal ulcers	No__
Gastritis or esophageal reflux	No__
Colitis	No__
Persistent diarrhea	No__
Hepatitis	No__
Other liver problems	No__

RESPIRATORY

Sinus trouble	No__
Asthma	No__
Persistent cough	No__
Bronchitis	No__
Emphysema or COPD	No__
Tuberculosis (TB)	No__
Breathing difficulty	No__

GENITO-URINARY

Urinate more than 6 times a day	No__
Kidney or bladder problems	No__
Dialysis	No__

OTHER CONDITIONS

Enlarged lymph node or "gland"		No__
Tobacco use		No__
Alcohol/Drug addiction		No__
Tumor or cancer	Yes__	No__
Radiation treatment		No__
HIV positive/AIDS		No__
Chemotherapy		No__

ALLERGIES-Are you allergic to:

Latex	No__
Local anesthetics "novocaine"	No__
Penicillin or other antibiotics	No__
Aspirin	No__
Codeine or other pain medication	No__
Chlorhexidine antiseptic or rinse	No__
Any other medicine list below:	

_____

Do you have any other disease, condition or problem not listed on this form? _____

_____

TO THE BEST OF MY KNOWLEDGE ALL OF THE ABOVE ANSWERS ARE TRUE AND CORRECT.

Patient's Signature_____ Date_____

I acknowledge and have received a copy of the Notice of Privacy Practices for the above named practice.

Patient's Signature_____