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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):

CARDIOVASCULAR			**GASTROINTESTINAL**		
Heart failure	Yes__	No__	Stomach or intestinal ulcers	Yes__	No__
Heart disease or attack	Yes__	No__	Gastritis or esophageal reflux	Yes__	No__
Angina or chest pain	Yes__	No__	Colitis	Yes__	No__
High blood pressure	Yes__	No__	Persistent diarrhea	Yes__	No__
Heart murmur	Yes__	No__	Hepatitis	Yes__	No__
Mitral valve prolapse	Yes__	No__	Other liver problems	Yes__	No__
Rheumatic fever	Yes__	No__			
Congenital heart defect	Yes__	No__	**RESPIRATORY**		
Artificial heart valve	Yes__	No__	Sinus trouble	Yes__	No__
Irregular heart beat (arrhythmia)	Yes__	No__	Asthma	Yes__	No__
Pacemaker or defibrillator	Yes__	No__	Persistent cough	Yes__	No__
			Bronchitis	Yes__	No__
HEMATOLOGIC			Emphysema or COPD	Yes__	No__
Blood transfusion	Yes__	No__	Tuberculosis (TB)	Yes__	No__
Anemia	Yes__	No__	Breathing difficulty	Yes__	No__
Sickle cell anemia	Yes__	No__			
Tendency to bleed longer than normal	Yes__	No__	**GENITO-URINARY**		
Hemophilia	Yes__	No__	Urinate more than 6 times a day	Yes__	No__
			Kidney or bladder problems	Yes__	No__
NEUROLOGICAL			Dialysis	Yes__	No__
Stroke	Yes__	No__			
Glaucoma or cataract	Yes__	No__	**OTHER CONDITIONS**		
Earaches or ringing in ears	Yes__	No__	Enlarged lymph node or "gland"	Yes__	No__
Severe headaches, migraines	Yes__	No__	Tobacco use	Yes__	No__
Fainting or dizzy spells	Yes__	No__	Alcohol/Drug addiction	Yes__	No__
Epilepsy, seizures, or convulsions	Yes__	No__	Tumor or cancer	Yes__	No__
Psychiatric treatment	Yes__	No__	Radiation treatment	Yes__	No__
			HIV positive/AIDS	Yes__	No__
ENDOCRINE			Chemotherapy	Yes__	No__
Diabetes	Yes__	No__	**ALLERGIES-Are you allergic to:**		
Thyroid disease	Yes__	No__	Latex	Yes__	No__
			Local anesthetics "novocaine"	Yes__	No__
DERMAL/ORAL/MUSCULOSKELETAL			Penicillin or other antibiotics	Yes__	No__
Skin rash or hives	Yes__	No__	Aspirin	Yes__	No__
Arthritis, rheumatism or gout	Yes__	No__	Codeine or other pain medication	Yes__	No__
Artificial joint	Yes__	No__	Chlorhexidine antiseptic or rinse	Yes__	No__
Fever blisters or canker sores	Yes__	No__	Any other medicine allergies list below:		

_____

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

_____

Patient's Signature_____ Date_____

I have been provided an opportunity to review the Notice of Privacy Practices for Sandhills Dental Rehabilitation Center (on the practice website or in office) and a printed copy of the Notice of Privacy Practices will be provided upon request.

Patient's Signature_____