John B. Oettinger, D.M.D.
Riley Allen, D.D.S, M.S.

Specialists in Prosthodontics

The following information will make it possible for us to be more successful and thorough in your treatment.

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 we are not in network with any insurance providers and 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? Please list:______________________________
____

Yes__ No__ Are you taking any blood thinners? If yes, please list with dose: ______________________________

Yes__ No__ Have you ever taken Bisphosphonates (Fosamax, Boniva, Reclast or Prolia) If yes, when was last dose:________

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 due 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

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__

GASTROINTESTINAL

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

RESPIRATORY

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

GENITO-URINARY

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

OTHER CONDITIONS

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

ALLERGIES-Are you allergic to:

Latex	Yes__	No__
Local anesthetics "novocaine"	Yes__	No__
Penicillin or other antibiotics	Yes__	No__
Aspirin	Yes__	No__
Codeine or other pain medication	Yes__	No__
Chlorhexidine antiseptic or rinse	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____