PATIENT INFORMATION and HEALTH HISTORY

Patient Information

Name: _____ Reason for today's visit: _____

Address: _____ City: _____ State: Zip: _____

Birthdate: _____ SSN: _____

Sex: M / F Marital Status: single / married / separated / divorced

Home Phone: _____ Cell Phone: _____ email: _____

Best way to contact you? call home / call cell / text cell / email

Employer/School: _____ Employer/School Phone: _____

Spouse/Parent Name: _____ Spouse/Parent Phone: _____

Whom may we thank for referring you? _____

Responsible Party

Name of Person Responsible for this Account: _____

Address: _____ City: _____ State: Zip: _____

Home Phone: _____ Cell Phone: _____ email: _____

Drivers License # _____ Birthdate: _____

Employer: _____ Work Phone: _____

Currently a patient in our office? Y / N Relation to Patient: _____

Insurance Information

Name of Insured: _____ Relation to Patient: _____

Birthdate: _____ Employer: _____ Employee ID: _____

Insurance Company: _____ Group #: _____

Address: _____ City: _____ State: Zip: _____

Dental History

Date of last dental care: _____ Date of last dental x-rays: _____

Previous dentist: _____ Address: _____

Check if you have experienced any of the following:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Food collecting between teeth
- ☐ Loose teeth or broken fillings
- ☐ Sensitivity to cold or hot or sweets
- ☐ Sensitivity when biting
- ☐ Periodontal treatment
- ☐ Sores or growths in your mouth

Tooth Decay Risk Factors

Check all that apply:

- ☐ Dry mouth during the day or when eating
- ☐ Frequent or prolonged exposure to sugar
- ☐ Chemo or radiation therapy in head and neck
- ☐ 3 or more cavities filled (or extracted) in last 3 years
- ☐ (Age < 14) Mother, sibling or caregiver had cavity in last 6 months
- ☐ (Age < 14) Special needs: mental physical or developmental disability

Medical History

Physician's name: _____ Date of last visit: _____

Have you had any serious illnesses or operations? Y / N _____

Have you ever had a blood transfusion? Y / N

Have you ever taken any of the group of drugs collectively referred to as "FEN-PHEN"? Y / N
(these include combinations of lonimin, Adipex, Fastin (phentaermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)).

Have you ever taken any BISPHOSPHONATES or other anti-resorptive drugs for osteoporosis or cancer treatment? Y / N

Check if you HAVE or HAVE HAD any of the following:

- ☐ Anemia
- ☐ AIDS/HIV
- ☐ Anxiety / Depression
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Pins, etc.
- ☐ Asthma
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Diabetes
- ☐ Emphysema
- ☐ Excessive Thirst
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Recreational Drug Use
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of feet and ankles
- ☐ Thyroid Problems
- ☐ Tingling/Numbness in face
- ☐ Tobacco or Alcohol Use
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

(Women)Are you pregnant? Y / N Nursing? Y / N Taking birthcontrol pills? Y / N

Check if you have EVER had an ALLERGIC / ADVERSE reaction to:

- ☐ Aspirin
- ☐ Sleeping Pills
- ☐ Codeine
- ☐ General Anesthesia
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Nitrous Oxide
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____
- ☐ Other _____

Current Medications (list below or attach copy)

_____

TMJ Screening

Have you ever had trauma to your face or jaws? Y / N Does your jaw pop or click? Y / N

Has your jaw ever locked open or locked closed? Y / N Did you wear braces/headgear? Y / N

Sleep Apnea Screening

Do you snore loudly? Y / N Do you experience daytime sleepiness or fatigue? Y / N

Has anyone noticed you choke, gasp or stop breathing while sleeping? Y / N

Do you have, or are you being treated for, HIGH BLOOD PRESSURE? Y / N

Age: _____ Are you currently under the care of a sleep physician? Y / N

Height (in): _____ Weight (lbs): _____ Neck circumference (staff will measure): _____