

Patient's Name _____ **Prefer to be called** _____

Date of Birth _____ **SS#** _____ **o Married o Single o Divorced o Widowed**

Address _____ **City/State/Zip** _____ **E-mail** _____

Home _____ **Work#** _____ **Cell#** _____ **(please circle preferred number)**

Place of Employment _____ **Occupation** _____

Person Responsible for this account (if not patient)

Relationship to patient _____ **Date of Birth** _____ **SS#** _____

Home Address (if different) _____

Home# _____ **Work#** _____ **Cell#** _____

Place of Employment _____ **Occupation** _____

Please check any of the following you are allergic to or have had a reaction to:

- Aspirin
- Codeine
- Latex or Rubber
- Local Anesthetics (like Novacaine)
- Metals, please list _____
- Penicillin
- Sulfa Drugs
- Other, please list _____

Please list any medications you are currently taking:

Please check any of the following that you have currently or have had in the past:

- Artificial Cardiac Valve
 - Heart Defect or Heart Murmur
 - Joint Replacement or Implant
 - Mitral Valve Prolapse
 - Rheumatic Fever
 - Stent Placement
- *****If you have checked any of these (or for any other reason), are you required by your physician to take prophylactic antibiotics prior to dental treatment? _____
- Prescribing physician _____
 Office # _____

Please check any of the following that you have currently or have had in the past:

- | | | |
|---|--|---|
| <input type="checkbox"/> Currently Pregnant or Nursing | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Currently taking blood thinners | <input type="checkbox"/> Kidney Trouble | |
| <input type="checkbox"/> Cancer, type/year _____ | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Currently taking Chemotherapy or Radiation | <input type="checkbox"/> Lupus | |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Mental Health Care | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Epilepsy or Seizures | **Please list any other medical condition that was not covered _____ | |
| <input type="checkbox"/> Hearing Impaired | | |
| <input type="checkbox"/> Heart Disease | | |

Treatment Assessment Please check any of the following that pertains to you.

Snoring

- Do you snore on most nights?
- Has anyone reported that you stop breathing or gasp in your sleep?
- Do you currently use a CPAP?

Dentures/Partials/Implants

- Do you have missing teeth that you would be interested in replacing?
- Do you have a denture or partial that is ill-fitting? Age of partial or denture _____

TMJ Disorder

- Do you wake up in the morning with soreness or a tired feeling in your jaw?
- Do you have frequent headaches?

Cosmetic

- Would you be interested in discussing ways we can enhance your smile?

Gum Disease

- Do you smoke?
- Have you ever been treated for gum disease?

Oral Conscious Sedation

- Do you experience anxiety during long dental procedures?
- Would you be interested in discussing sedation options we have available for dental treatment?

I certify that I have read and understand the above information and have answered the questions accurately. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information contained in my patient file as deemed necessary by Dr. Vance. I authorize my insurance company to pay directly to Dr. Vance. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient or Legal Guardian _____

Date _____