Shaganappi Dentistry

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SHAGANAPPI DENTISTRY PATIENT DENTAL AND MEDICAL INFORMATION

GENERAL INFORMATION

Name:_____ _____ Sex_____ DOB_____
First Last
Address:_____City:_____ Postal Code_____

Home/Cell Phone:_____Bus. Phone: _____E-Mail:_____

Occupation_____Employer:_____

Reason for visit to our dental office:_____Referred by_____

Dental Insurance
(primary) Name of Policy holder:_____ DOB _____
Company_____Group No._____Cert/ID No._____

(Secondary) Name of policy holder:_____DOB_____
Company_____ Group No._____Cert/ID No._____

MEDICAL INFORMATION

Physicians Name and contact information:_____

Pharmacy Name and contact information:_____

Medications List:

Drug	Dose	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

History of use of bisphosphonates (osteoporosis) medication in the last 10 years Yes No

Have you been informed not to take any specific drug or medication? Yes No
Please list_____

Do you have **Allergies** or **adverse reactions** to any of the following:

Dental Anaesthesia	yes	no	Aspirin	yes	no
Penicillin or other Antibiotics	yes	no	Codeine	yes	no

Latex yes no Benzodiazepine (sedative) yes no

Please list any **allergies, symptoms** and what type of **management** (ex. epi pen, antihistamine).

_____

Do you have or had any of the following medical concerns?

Asthma	yes no	HIV Positive/AIDS	yes no
Heart Surgery	yes no	Hip/Joint replacement	yes no
Artificial Heart Valve	yes no	Epilepsy	yes no
Heart Attack	yes no	Diabetes	yes no
Heart Murmur	yes no	Hepatitis	yes no
Pacemaker	yes no	Arthritis	yes no
High Blood Pressure	yes no	Ulcers	yes no
Stroke	yes no	Tuberculosis	yes no
Scarlet Fever	yes no	Emphysema	yes no
Anemia	yes no	Glaucoma	yes no
Abnormal Blood Count	yes no	Hives or skin rash	yes no
Hemophilia	yes no	Hay fever	yes no
Major operations	yes no	shortness of breath/chest pain	yes no
Blood Transfusions	yes no	Dry mouth	yes no
Tumor or Growth	yes no	Tobacco Use	yes no
Cancer/Leukemia	yes no	How many/years _____	
Radiation/Chemotherapy	yes no	When did you stop_____	

Please list any disease, or condition not covered._____

Do you have a history of medical surgery or hospitalizations? Yes No

Details:_____

Have you had abnormal bleeding associated with pervious tooth extractions, surgery or trauma? Yes No

Please list management_____

Have you ever had surgery or radiation treatment for a tumor, growth or condition of your head mouth or lips? Yes No

Do you have a new cough or shortness of breath Yes No

New fever or chills in the last 24 hours Yes No

New onset of diarrhea Yes No

New undiagnosed rash,lesion,or break in skin Yes No

Recent exposure to communicable infectious disease,eg measles,ckicken pox or tuberculosis Yes No

History of antimicrobial therapy Yes No

HX of medications which could be immunosuppressive(eg chemotheraphy) Yes No Family history of Prion disease, or symptoms that may be indicative of CJD Yes No

FOR WOMEN ONLY

Are you pregnant at this time? Yes___ NO___ Due Date:_____

Are you taking female hormones oral contraceptives (may be altered with antibiotics) Yes No

DENTAL INFORMATION

Please inform us of any Dental Concerns (ex. Difficulty Chewing food, Sensitivity, Discomfort)

_____

Are you aware of any of the following?

Bleeding gums:	Yes No	Esthetic concerns	Yes No
Bad taste or breath	Yes No	Shifting/loose teeth	Yes No
Receding gums	Yes No	Clenching/grinding	Yes No
Sensitive teeth	Yes No	Gagging	Yes No
Acid reflux	Yes No	Jaw click or soreness	Yes No

Do you wear a night guard? Yes No ; if yes, when was it fabricated_____
Do you wear a Denture? Yes No; if yes, please indicate type _____

Have you ever had previous periodontal treatment? Yes No
When and what sites were involved? _____

Have you ever had orthodontic treatment ? _____ Yes No

Have you ever had instruction on how to care for your teeth? Yes No
Does this include the following:
Soft brush_____, Floss_____, Proxabrush_____, Sulca Brush_____
Please answer the following questions related to your personal dental care.
Frequency of brushing_____Firmness of brush_____
Frequency of flossing_____Other dental aids_____
Regularity of cleanings_____
Have you ever had complications associated with any previous dental treatment? Yes No
Please clarify_____

TO THE BEST OF MY KNOWLEDGE, ALL THE PRECEEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH OR IF MY MEDICINES CHANGE, I WILL INFORM THE DENTAL STAFF AT THE NEXT APPOINTMENT WITHOUT FAIL.

SHORT NOTICE CANCELLATIONS AND APPOINTMENT NO-SHOW's MAY BE SUBJECT TO A FEE. THANK YOU

Signed _____Date_____