SPECIALISTS IN IMPLANT DENTISTRY

***Personal Information*:**

Name: _____ Date of Birth: _____
Emergency Contact Name: _____ Phone: _____
Address: _____ City:_____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work/Northern: _____
Email: _____ Referred By: _____

Current Health: Excellent Good Fair Poor Date of Last Medical Exam: _____

Please check any conditions that apply to you now or in the past (*circle specific answers*):

ALLERGIES:
Anesthesia (Local, IV, General)
Hay Fever
Latex
Penicillin
Other: _____

CANCER:
Radiation to head/neck
Chemotherapy
If Yes, please explain what type of cancer and last date of treatment:
_____
_____
_____

HEART:
AFIB/Arrhythmia/Pacemaker
Artificial Heart Valve
Aspirin Therapy
Blood Thinner:_____
Bypass/Stents Heart Attack/Heart Disease Heart Murmur/MVP
High/Low Blood Pressure
Heart Failure (CHF)

KIDNEYS/LIVER/STOMACH:
Diabetes/Pre-Diabetic
Dialysis/Kidney Transplant
Jaundice/Liver Transplant
Hepatitis: A B C
Acid Reflux/GERD/IBS
Celiac Disease/Ulcers
Other: _____

LUNGS:
Asthma
COPD/Emphysema
Sleep Apnea/CPAP Machine
Other: _____

NEUROLOGICAL:
Anxiety/Depression
Alzheimer's
Dementia/Memory Loss
Epilepsy/Seizures
Fibromyalgia/Chronic Pain
MS/Parkinson's
Stroke/TIA
Other: _____

ORTHOPEDIC:
Arthritis
Back/Neck Problems
Hip Replacement/Pre-med?
Knee Replacement/Pre-med?
Other: _____
Osteoporosis
Osteo Meds: Please check
Actonel/Atelvia
Boniva
Fosomax
Prolia/Xgeva
Reclast/Zometa
How Long: _____
Last Dose: _____

OTHER:
Alcoholism/Drug Abuse
Autoimmune Disease (RA/Lupus)
Cataracts/Glaucoma
Cold Sores/Shingles
HIV
Thyroid/Parathyroid Disease
Tobacco Use
Currently pregnant: Yes/No

Please list **all** serious illness or surgeries past or present: _____

_____

Please list **all** medications you currently take: _____

_____

Are you currently under a physician's care: No / Yes (reason): _____

The above information is correct to the best of my knowledge, and I have received a copy of the office financial policy:

_____

Signature Date

SPECIALISTS IN IMPLANT DENTISTRY

Dental History

Please describe your current dental health: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

How did you hear of us? Friend/Family: _____ ☐ TV ☐ Newspaper ☐ Seminar

Anxiety Level (please check): ☐ Fearless ☐ Indifferent ☐ Trembling/Anxious

Is this your first consultation regarding dental implants: ☐ YES ☐ NO

Please explain what symptoms or tooth related concerns prompted this visit:

☐ Difficulty Chewing
☐ Pain
☐ Infected Teeth
☐ Facial Swelling
☐ Missing Teeth
☐ Lack of Social Interaction
☐ Dentures/Partials
☐ Bad Breath
☐ Embarrassment
☐ Failing Dental Work
☐ Broken Teeth
☐ Failing Dental Implants
☐ Other

COMMENTS: _____

_____

Have you ever been diagnosed with periodontal disease: ☐ YES ☐ NO
If yes, do you currently have loose teeth: ☐ YES ☐ NO

Please specify what treatment you are most interested in:
☐ Full Mouth ☐ Single Tooth ☐ Upper Teeth/Arch ☐ Lower Teeth/Arch

DENTURES: How long have you worn dentures: _____

What is your chief complaint: ☐ Ill-Fitting/Pain ☐ Difficulty Chewing ☐ Gag Reflex

Other: _____

Shade or mark the area(s) of your mouth that are in pain in the diagram below:

Notes: _____

_____

_____

_____

_____

Signature **Print Name** **Date**