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Emerging science confirms that chronic low-grade infections in the mouth elevates systemic inflammation and has an impact on all body systems. The mouth is further linked with the rest of the body when considering the impact of oral airway and sleep apnea, TMD and headaches, dental caries infections and oral cancer. The significance of these numerous mouth-body and oral systemic connections highlight the importance of preventing and treating oral disease which has mounting and profound medical impacts on "whole body" health. "Oral Health" must therefore have a new definition and be supported by an organization inclusive of all medical professionals so patients will enjoy the resulting benefits of improved oral and general health, healing, longevity and wellness. – The American Academy for Oral Systemic Health

Patient Information:

Name_____ Sex - M/F Date of Birth_____

Social Security #_____

Address_____

City/State/Zip Code _____

Home #_____ Cell #_____ Work #_____

Email_____ Employer_____

Marital Status_____ Spouse's Name _____

Emergency Contact_____ Relationship to Patient _____

Emergency Contact #_____

Who may we thank for referring you to our office? _____

Who is responsible for this account, if not yourself? _____

Dental Insurance Information:

Subscriber's Name: _____ Date of Birth: _____

Address: _____ Phone: _____

SS #: _____ Employer: _____ Phone: _____

Insurance Company _____ Ins Co Phone # _____

Claims Mailing Address _____

Member ID# _____ Group # _____

Patient's relationship to subscriber: Self_____ Spouse _____ Dependent _____

Are you covered by more than one dental insurance plan? Y N *If yes, complete the following:*

Subscriber's Name: _____ Date of Birth: _____

Address: _____ Phone: _____

SS #: _____ Employer: _____ Phone: _____

Insurance Company _____ Ins Co Phone # _____

Claims Mailing Address _____

Member ID# _____ Group # _____

Patient's relationship to subscriber: Self_____ Spouse _____ Dependent _____

While the dental office will do all possible to help you maximize your dental benefits, I understand that I am ultimately responsible for all fees regardless of insurance coverage.*

Signature of patient/parent_____

***An appointment is considered a reservation specifically for the patient. The office does charge a $50 broken reservation fee for appointments cancelled giving less than 24 hours notice. If such a charge is incurred, I understand I am responsible for paying that before more appointments can be scheduled. ***

Signature of patient/parent _____

Patient Name: _____ **Primary Care Physician:** _____

Dr. Office #: _____ **Date of Last Medical Visit:** _____

Reason for today's visit if not routine:_____

If not at our office, when was your last cleaning ?_____
Comprehensive exam?_____Xrays?_____

How often do you brush your mouth? _____ How often do you floss?_____

Have you ever been told you have periodontal (gum/bone) disease? **Y/N** If yes, did you receive treatment?_____ Describe treatment:_____
_____

Are you nervous about having dental treatment? **Y/N** If yes, explain:_____
_____

Is there a way we can make you more comfortable during treatment?_____
_____

How do you feel about the appearance of your teeth?_____
If you could change anything, what would you change about your smile?_____
_____

Do you have any of the following problems?

Tooth Sensitivity	Clenching	Swollen Gums	Headaches	Grinding
Sleep Apnea	Bleeding Gums	Bad Breath	Jaw Joint Issues/Pain	

MEDICAL HISTORY

1) Have you ever used a bisphosphonate medication? (Common brand names are Fosamax, Atelvia, Didronel, Boniva, Reclast) **YES or NO**

2) Have you ever taken any of the drugs collectively referred to as "fen-phen?" (Common names are Ionimin, Adipex, Fastin, Pondimin, Redux) **YES or NO**

3) Have you ever had any serious illnesses or operations? **YES or NO** If yes, please describe_____
_____

4) Have you ever had a blood transfusion? **YES or NO** If yes, when?_____

5) **Women -→** Are you pregnant? **YES or NO** Nursing? **YES or NO**
Taking birth control pills? **YES or NO**

6) Do you have any artificial joints or valves, chemotherapy port or stent, or other medical concerns that requires you to take a pre-medication before dental cleanings? **YES or NO**
If yes, what is your situation and when was it placed? (Your doctor who performed the procedure will generally advise you.)

_____

_____

_____

Pre-Med To Take: Amoxicillin Clindamycin Other:_____

Have you been treated by a doctor, or been hospitalized in the past 2 years? **Y/N** If yes, explain:_____

_____

Have you ever been treated for bleeding or a tumor? **Y/N** Explain:_____

_____

Please list any medications (prescription, herbal, over-the-counter, birth control, vitamins, etc) you are **currently taking or have taken in the past year:**_____

_____

_____

_____

_____

_____

Do you have any **allergies** to any of the following? Please circle the ones that apply. If not, please circle **NONE.**

*Aspirin	*Ibuprofen	*Tylenol	*Adhesive	*Latex
*Biaxin	*Ceclor	*Clindamycin	*Codeine	*Epinephrine
*Cipro	*Keflex	*Morphine	*Oxycodone	*Penicillin
*Tetracycline	*Sulfa	*Erythromycin		

*Any other medicinal allergies that aren't listed here?_____

_____

_____

_____

Other allergies (seasonal, food, etc.):_____

_____

_____

Are you a smoker or dipper? Past or Present?_____

Please circle any of the following medical/dental conditions that may apply:

AIDS/HIV+
Alzheimer's Disease
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Transfusion
Breathing Problems
Bruising Easily
Cancer
Chemotherapy
Chest Pains
Cold Sores/Fever Blisters
Congenital Heart Disorder
Cortisone Medicine
Depression
Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy/Seizures
Excessive Bleeding
Excessive Thirst
Fainting/Dizziness
Frequent Diarrhea
Frequent Headaches
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Pacemaker/Defib
Heart Disease
Hemophilia
Liver Disease
Hepatitis A, B, C
Herpes
High Blood Pressure
Hives or Rashes
Hypoglycemia
Irregular Heartbeat
Kidney Stones
Leukemia
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Parathyroid Disease
Psychiatric/ Mental Care
Radiation Treatment
Recent Weight Loss
Renal Dialysis
Rheumatic Fever
Rheumatism
Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Spina Bifida
Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors/Growths
Ulcers
Yellow Jaundice
Tobacco Habit

Any condition not listed above: _____

Cancer → Past or Present? Type?_____

Have you ever had Radiation Treatment or Chemotherapy? If so, when?_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health or medications, I will inform the dentist at my next appointment without fail.

Patient/Parent signature_____ Date _____