Aesthetic Dental
DENTURES & IMPLANTS

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PATIENT INFORMATION

Name (First, MI, Last)_____ DOB _____Sex M F
Address_____ Zip _____
Home Phone _____Mobile _____ E-Mail _____
Employer _____ Work_____

How did you hear about Aesthetic Dental? _____

Name of Physician _____
Physician Office # _____ Physician Office Fax #_____
Date of last physical _____ (if known)

In case of emergency contact _____ Phone _____

DENTAL HEALTH INFORMATION – CONFIDENTIAL

Reason for today's office visit _____
Date of last dental visit _____ Cleaning _____

DO YOU HAVE ANY HISTORY OF: *(CHECK ALL THAT APPLY)*

- ❑ Rheumatic fever
- ❑ Heart Murmur (with registration)
- ❑ Heart abnormalities since birth
- ❑ Heart Trouble
- ❑ Heart attack Date(s) _____
- ❑ Pace Maker/Open Heart Surgery
- ❑ Date(s) _____
- ❑ Have you had any stents?
- ❑ When? _____How many? _____
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ H.I.V. Positive
- ❑ Diabetes (if yes) Type I ☐ Type II ☐
- ❑ Stroke Date(s) _____
- ❑ Excessive Bleeding
- ❑ Any Artificial Joint Replacements
- ❑ Date(s) _____
- ❑ Anemia
- ❑ Hepatitis
- ❑ Lung Disease
- ❑ Breathing Problems
- ❑ Tuberculosis (if yes, is your tuberculosis
- ❑ currently active?) Yes ☐ No ☐
- ❑ Asthma
- ❑ Epilepsy/Seizures Petit ☐ Grand Mal ☐
- ❑ Last seizure episode _____
- ❑ Fainting or Dizziness
- ❑ Venereal Disease (please list)

_____

- ❑ Arthritis
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Currently taking any bisphosphonates
- ❑ such as Fosamax, Actonal, etc?
- ❑ Any surgery or radiation treatment for a tumor, cancer or other condition?
- ❑ Presently under care of a Physician

❑ Trouble from previous dental care (please explain briefly)

_____

❑ Growths of sore spots in mouth
❑ Have Novacain/oth local anesthetic
❑ Have had Nitrous Oxiide (laughing gas)
❑ Have had General Anesthesia
❑ Allergic reaction to Novacain, local or general anesthesia
❑ Difficult extractions
❑ Your gums bleed
❑ Bad taste or odor in your mouth
❑ Chew on only one side of your mouth
❑ Other illnesses (explain below) _____

❑ Unhealed injuries or inflamed areas in or around your mouth
❑ Any part of the mouth sensitive to pressures or irritants (hot, cold or sweets)
❑ Pain in your jaw or near your ears
❑ Popping or clicking in jaws or TMJ
❑ Treated/diagnosed with TMJ disorder
❑ Sinus problems
❑ Sleep apnea

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WOMEN NOTE

❑ Is there a possibility of pregnancy? (if yes, estimate due date) _____
❑ I am currently nursing
❑ I am currently taking birth control pills

Antibiotic (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control

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Do you take any "blood thinners" such as Asprin, Coumadin, Plavix, Pradaxa, Xarelto etc?

☐ Yes ☐ No

List any medication you are taking including non-prescription drugs: ☐ None

Are you allergic to any medications? ☐ Yes (please list below) ☐ No

If wearing dentures, age of dentures: _____

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors that I have made in the completion of this form.

Signature _____ Date_____

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Guardian Information Patient Name: _____
Guardian Name: _____
(if patient is a minor, parent or guardian must sign here)
Signature _____ Date _____