Welcome to

The fields on this PDF form are all "fillable." Type all your answers below, save the document as PDF, print or email it to us, or you may also print this document and hand-write your answers

Medical Alert

Awake or Asleep Dentistry

Patient Information (PLEASE PRINT CLEARLY)

A parent or guardian will be responsible for decisions on my treatment ☐ Yes ☐ No

Name: _____ Sex: ☐ Male ☐ Female
First Initial Last

Email Address: _____ **Cell#**: (___)_____

Address: _____
Street Apt. City Prov. Postal Code

Date of Birth: __ / __ / __ Home#: (___)_____ ☐ Single ☐ Married
D M Y

Employer: _____ Work#: (___)_____

Occupation: _____ # of years employed _____

Emergency Contact: _____ Tel. (___)_____

Family Doctor: _____ Tel. (___)_____

How did you hear about us? _____

Referring Dentist: _____ Tel. (___)_____

Driver's Lic.: _____ **OR** ID#: _____

PRIMARY INSURANCE

Member's Full Name: _____ Date of Birth: __ / __ / __
D M Y

Ins.Company: _____ Tel. (___)_____

Employer: _____ Ins. Yr. End: _____

Policy#: _____ Certificate#: _____

Max Cov. _____ % coverage for _____ Basic _____ Maj. Restorative _____ Orthodontic

SECONDARY INSURANCE

Member's Full Name: _____ Date of Birth: __ / __ / __
D M Y

Ins.Company: _____ Tel. (___)_____

Employer: _____ Ins. Yr. End: _____

Policy#: _____ Certificate#: _____

Max Cov. _____ % coverage for _____ Basic _____ Maj. Restorative _____ Orthodontic

Although you are providing insurance information, we cannot accept payment directly from an insurance company. Please Initial _____

Medical History **(this information will remain confidential)** Date: _____

	YES	NO
1. Are you presently under the care of a physician?	☐	☐
If so, explain. _____		
2. Have you ever been hospitalized?	☐	☐
Please explain. _____		
3. Are you taking any drugs or medication at this time?	☐	☐
A) Drug _____ Reason _____		
B) Drug _____ Reason _____		
C) Drug _____ Reason _____		
D) Drug _____ Reason _____		
4. Have you ever had any adverse effect to any of the following:		
Antibiotic - Penicillin ☐, Sulfonamide ☐, Other ☐; **Aspirin** ☐; **LATEX** ☐;		
Sleeping pills ☐; **Codeine** ☐; **Local Anesthetic** ☐; **NONE** ☐.		
5. Have you ever been warned against using any medications?	☐	☐
Which? _____		
6. Have you ever taken prolonged medical or non-medical drugs?	☐	☐
Which? _____		
7. Do you suffer from any allergies (hay fever, **latex**, etc.)?	☐	☐
8. Which? _____		
9. Do you bruise easily or have prolonged bleeding?	☐	☐
10. Do you smoke? How much per day? _____	☐	☐
11. Have you ever fainted, had shortness of breath or chest pains?	☐	☐

11. **WOMEN** Are you pregnant? Yes ☐ No ☐ Using birth control? Yes ☐ No ☐
Reached menopause? Yes ☐ No ☐

12. Do you have or have you ever had any of the following? Please ✓ appropriate boxes. **NONE** ☐

☐ A.I.D.S.	☐ Glandular disorders	☐ Lung disease
☐ Anemia	☐ Glaucoma	☐ Malignant hyperthermia
☐ Angina Pectoris	☐ Head/neck injuries	☐ Mental/nervous disorder
☐ Anorexia nervosa	☐ Heart disease/attack	☐ Mitral valve prolapse
☐ Artificial Heart valve	☐ Heart murmur	☐ Organ transplant/implant
☐ Arthritis/rheumatism	☐ Heart pacemaker/surgery	☐ Psychiatric disorder
☐ Artificial joints (hips, knee)	☐ Heart rhythm disorder	☐ Radiation/chemotherapy
☐ Asthma	☐ Hepatitis A/B/C	☐ Rheumatic/Scarlet fever
☐ Blood disorders	☐ Herpes	☐ Sickle Cell disease
☐ Bronchitis	☐ High blood pressure	☐ Sinus trouble
☐ Bulimia	☐ Low blood pressure	☐ Stomach/intestinal problems
☐ Cancer	☐ H.I.V. positive	☐ Stroke
☐ Circulation problems	☐ Hodgkin's disease	☐ Thyroid disease
☐ Congenital heart lesions	☐ Hyper (Hypo) glycemia	☐ Tuberculosis
☐ Cortisone/steroid	☐ Hypertension	☐ Ulcers
☐ Diabetes	☐ Jaundice	☐ Venereal disease
☐ Drug/alcohol dependence	☐ Kidney disease	☐ Sleep apnea
☐ Emphysema	☐ Liver disease	☐ Other _____
☐ Epilepsy	☐ Leukemia	☐ Other _____

13. Do you require sedation for your regular dental care? Yes ☐ No ☐ Not Sure ☐

14. **CHILDREN** Have you recently had any of the following (approximate date)?

☐ Chicken Pox _____ ☐ Measles _____ ☐ Mumps _____
☐ Strep Throat _____ ☐ Tonsillitis _____ ☐ NONE

Dental History

1. What is the reason for today's visit?

   ☐ Emergency ☐ Examination ☐ other _____

2. How frequently do you see a dentist? _____

3. When was your last dental visit? _____ Last X-Ray? _____

4. How often do you brush per day? _____ Floss? _____ Use anti-bacterial rinse? _____

5. Are your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other _____

	YES	NO
6. Do your gums bleed?	☐	☐
7. Do your gums feel swollen or tender?	☐	☐
8. Do you have bad breath or a bad taste in your mouth?	☐	☐
9. Do you have any discomfort or problems when your jaws are opened widely?	☐	☐
10. Do you grind or clench your teeth?	☐	☐
11. Do you have food catch between your teeth?	☐	☐
12. Have you ever had dental freezing?	☐	☐
Any complications? ☐ Yes ☐ No Specify _____	☐	☐
13. Have you ever had any problems with previous dental treatments?	☐	☐

Please explain _____

14. Have you ever had any of the following: ☐ Bridgework ☐ Crowns or Caps

☐ Root Canal ☐ Full or Partial Dentures ☐ Orthodontic (braces) ☐ Periodontal (Gums)

15. Rate your smile from 1 to l0 (1 = very unsatisfied, 10 = very satisfied).

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

1 2 3 4 5 6 7 8 9 10

GENERAL RELEASE / PATIENT CONSENT

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

_____ _____ _____

Signature ☐ Self ☐ Parent/Guardian Print name Date