DREW DENTAL

783 Rio Del Mar Blvd. Aptos, CA 95003 831.688.6060 info@drewdental.com
Family | Cosmetic | Invisalign | Implants

PLEASE PRINT Date _____

Patient Name _____ Sex: M F Birthdate _____
First MI Last

❑ Single ❑ Married ❑ Partner ❑ Widowed ❑ Dependent Child Email
_____

Address _____
City State Zip

Phone Home_____ Work_____ Cell_____

Emergency contact: _____ Phone _____ Relationship _____
(Friend or relative not living with you)

Referred by: _____

Physician or Clinic _____Phone _____

Pharmacy (we can use to call in medication:)_____

Last Medical Exam _____ Premedication needed for appointments?_____

I give my consent to use local anesthetic, general anesthetic, or relaxants for completing necessary dental treatment.

Signed_____ Date_____
(parent if child is minor)

I, _____ I have received a copy of the DENTAL MATERIALS FACT SHEET.
(please print name)

I understand I will also receive and acknowledge a copy of the Drew Dental privacy policy

Patient Signature_____ Date:_____
(Signature for form parent if minor)

Medical History _

Height _____Weight _____

Yes No	Yes No	Yes No
❑ ❑ Substance abuse	❑ ❑ Lung disease	❑ ❑ Thyroid condition
❑ ❑ Heart murmur/trouble	❑ ❑ Cancer	❑ ❑ Bleeding tendency
❑ ❑ Heart or chest pain	❑ ❑ Asthma	❑ ❑ Anemia
❑ ❑ Rheumatic fever	❑ ❑ Bronchitis	❑ ❑ Surgical implant
❑ ❑ Pacemaker	❑ ❑ Diabetes	❑ ❑ Joint Replacement
❑ ❑ Prosthetic valve	❑ ❑ Kidney disease	❑ ❑ Venereal disease
❑ ❑ Sinus problems	❑ ❑ Liver disease	❑ ❑ HIV positive
❑ ❑ High blood pressure	❑ ❑ Hepatitis	❑ ❑ Herpes
❑ ❑ Low Blood Pressure	❑ ❑ Convulsions/epilepsy	❑ ❑ Psychiatric treatment
❑ ❑ Recent cough or cold	❑ ❑ Nose obstruction	❑ ❑ Headaches or ear pains
❑ ❑ Facial radiation therapy	❑ ❑ Cortisone or ACTH	❑ ❑ High Cholesterol

Allergy or unusual reaction to:

Yes No	Yes No
❑ ❑ Penicillin	❑ ❑ Latex
❑ ❑ Clindamycin	❑ ❑ Epinephrine
❑ ❑ Sulfa	❑ ❑ Novocaine
❑ ❑ Azithromycin	❑ ❑ Norco/Vicodin
❑ ❑ Aspirin	❑ ❑ Codeine
❑ ❑ Milk	❑ ❑ Nitrous
❑ ❑ Ibuprofen	❑ ❑ Acetaminophen
❑ ❑ Valium/Halcion/Xanax	
❑ ❑ Other Drugs_____	

Do you take anticoagulants / blood thinners? (incl. daily aspirin) ❑ Yes ❑ No explain _____
Have you ever had excessive bleeding requiring special treatment? ❑ Yes ❑ No explain _____
Have you ever taken bisphosphonates? ❑ Yes ❑ No such as zoledronate, pamidronate, fosamax, boniva, actonel
Do you smoke? ❑ Yes ❑ No If yes how much? _____ pack(s) per day
Do you get short of breath easily? ❑ Yes ❑ No explain _____
Have you ever fainted? ❑ Yes ❑ No explain _____
Have you ever had general anesthesia? ❑ Yes ❑ No explain _____
Have you been hospitalized within the last 5 years? ❑ Yes ❑ No explain _____
Are you under the care of a physician? ❑ Yes ❑ No explain _____
Have you ever responded unfavorably to medical or dental care? ❑ Yes ❑ No explain
_____
Do you like to use Nitrous Oxide for dental visits? ❑ Yes ❑ No explain
_____
Do you like to use oral sedation for your dental treatment? ❑ Yes ❑ No Available options: Halcion, Valium, Xanax
Must you sleep with your head on more than one pillow? ❑ Yes ❑ No explain
_____
Any medical condition or problems not listed above? ❑ Yes ❑ No explain
_____ **Are you now taking any medications? Please list all medications** ❑ Yes ❑ No
explain _____

Women only: Pregnant? ❑ Yes ❑No Breast feeding? ❑ Yes ❑ No Birth control pills? ❑ Yes ❑ No

Delivery date? _____ OB Dr. _____

Dental Information

Are you in dental discomfort today? ❑ Yes ❑ No
Do you clench or grind your teeth? ❑ Yes ❑ No
Do you have frequent "tension" headaches? ❑ Yes ❑ No
Are you missing any teeth? ❑ Yes ❑ No
_____
Have they been replaced? ❑ Yes ❑ No
_____
Do your gums bleed when you floss or brush? ❑ Yes ❑ No
_____
Have you been treated by a periodontist (gum specialist)? ❑ Yes ❑ No
_____
Have you ever had orthodontic treatment? ❑ Yes ❑ No _____
Are any of your teeth sensitive to: ❑ Hot? ❑ Cold? ❑ Sweets? ❑ Pressure?
Previous dentist: _____ Phone #: _____

Is there anything you would like us to know about your dental health or previous dental treatment? And what would you like us to do for you today?

How long has it been since your last dental treatment? _____ How do you feel about the appearance of your teeth? _____

Updates

Signature_____ Date_____ Signature_____Date_____

Signature_____ Date_____ Signature_____Date_____