

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)

Patient Signature _____ Date: _____

(Signature for form parent if minor)

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

Medical History

Height _____ Weight _____

Yes No

- Substance abuse
- Heart murmur/trouble
- Heart or chest pain
- Rheumatic fever
- Pacemaker
- Prosthetic valve
- Sinus problems
- High blood pressure
- Low Blood Pressure
- Recent cough or cold
- Facial radiation therapy

Yes No

- Lung disease
- Cancer
- Asthma
- Bronchitis
- Diabetes
- Kidney disease
- Liver disease
- Hepatitis
- Convulsions/epilepsy
- Nose obstruction
- Cortisone or ACTH

Yes No

- Thyroid condition
- Bleeding tendency
- Anemia
- Surgical implant
- Joint Replacement
- Venereal disease
- HIV positive
- Herpes
- Psychiatric treatment
- Headaches or ear pains
- High Cholesterol

Allergy or unusual reaction to:

Yes No

- Penicillin
- Clindamycin
- Sulfa
- Azithromycin
- Aspirin
- Milk
- Ibuprofen
- Valium/Halcion/Xanax
- Other Drugs _____

Yes No

- Latex
- Epinephrine
- Novocaine
- Norco/Vicodin
- Codeine
- Nitrous
- Acetaminophen

- 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 Is there anything you would like us to know about your dental health
- Do you clench or grind your teeth? Yes No or previous dental treatment? And what would you like us to do for you today?
- 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 #: _____

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

Updates

Changes •Yes •No Signature_____ Date_____ Provider_____

Changes •Yes •No Signature_____ Date_____ Provider_____