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	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	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
Do you have frequent "tension" headaches?	❑ Yes ❑ No	you today?
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_____