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

Physician or Clinic _____ Phone _____ Date of Last Medical Exam _____

Previous dentist: _____ Phone #: _____ When was your last dental treatment?_____

Pharmacy (we can use to call in medication:)_____Premedication needed for dental appointments?_____

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

Signed_____ Date_____
(parent if child is minor)

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

Patient Signature (parent if minor)_____Date:_____

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

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Is there anything you would like us to know about your dental health or previous dental treatment? How we can help you today?_____
_____
_____

How do you feel about the appearance of your teeth?

Dental Information

Are you in dental discomfort today?	❑ Yes ❑ No	Have you ever had orthodontic treatment?	❑ Yes ❑ No
Are you missing any teeth?	❑ Yes ❑ No	Do you grind your teeth?	❑ Yes ❑ No
Have they been replaced?	❑ Yes ❑ No	Do you clench your teeth?	❑ Yes ❑ No
Have they been replaced?	❑ Yes ❑ No	Do you have frequent “tension” headaches?	❑ Yes ❑ No
Do your gums bleed when you floss or brush?	❑ Yes ❑ No	Do you wear a nightguard?	❑ Yes ❑ No
Have you been treated by a periodontist?	❑ Yes ❑ No	Are any of your teeth sensitive to: ❑ Hot? ❑ Cold? ❑ Sweets? ❑ Pressure	

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
❑ ❑ Fibromyalgia
❑ ❑ Sleep Apnea

Yes No
❑ ❑ Lung disease
❑ ❑ Cancer
❑ ❑ Asthma
❑ ❑ Bronchitis
❑ ❑ Diabetes
❑ ❑ Kidney disease
❑ ❑ Liver disease
❑ ❑ Hepatitis
❑ ❑ Convulsions/epilepsy
❑ ❑ Nose obstruction
❑ ❑ Cortisone or ACTH
❑ ❑ GERD

Yes No
❑ ❑ Thyroid condition
❑ ❑ Bleeding tendency
❑ ❑ Anemia
❑ ❑ Surgical implant
❑ ❑ Joint Replacement
❑ ❑ Venereal disease
❑ ❑ HIV positive
❑ ❑ Herpes
❑ ❑ Psychiatric treatment
❑ ❑ Headaches or ear pains
❑ ❑ High Cholesterol
❑ ❑ Acid Reflux

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 take Supplements? ❑ Yes ❑ No explain_____
Do you use Sleep Aids? ❑ Yes ❑ No explain_____
Have you been told you snore or stop breathing at night? ❑ Yes ❑ No explain _____
Have you been diagnosed with Sleep Apnea? ❑ Yes ❑ No explain_____
Do you wear a CPAP? ❑ Yes ❑ No Have you in the past? ❑ Yes ❑ No Have you been told to? ❑ Yes ❑ No _____
Have you had a Sleep Study or been told to get a Sleep Study? ❑ Yes ❑ No _____

Are you now taking any medications? ❑ Yes ❑ No **Please list all medications**:_____
_____

Do you smoke? ❑ Yes ❑ No If yes how much? _____ pack(s) per day
Do you get short of breath easily? ❑ Yes ❑ No explain _____
Must you sleep with your head on more than one pillow? ❑ 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
Any medical condition or problems not listed above? ❑ Yes ❑ No explain _____

Women only: Pregnant? ❑ Yes ❑No Breast feeding? ❑ Yes ❑ No Birth control pills? ❑ Yes ❑ No
What is your Delivery date? _____ OB Dr. _____

Patient Signature_____ Date_____ Provider Signature_____

Updates

Changes: Yes/No? Signature _____ Date_____ Provider_____

Changes: Yes/No? Signature_____ Date_____ Provider_____

Changes: Yes/No? Signature_____ Date_____ Provider_____