SUNDANCE DENTAL

Name:		Today's Date:
Address:		Postal Code:
Phone HM:	Work:	Cell:
Date of Birth:	Gender: M F	Email Address:
Employer:		Occupation:
Emergency Contact:		Phone#:

Physician: _____ Phone: _____ Previous Dentist: _____ Phone#: _____

Medical History

Are you under a physician's care now? Y / N If yes, _____
Have you ever been hospitalized or had a major operation? Y /N If yes, _____
Are you taking any Medications, pills or drugs? Y / N If yes, _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Y / N
Do you use tobacco? Y /N
Do you use controlled substances? Y /N If yes, _____
Are you allergic to any of the following? Aspirin / Penicillin / Codeine / Acrylic / metal / Latex / Sulfa Drugs / Local Anesthetics / other: _____

Please circle any of the following conditions that apply to you, past or present

Anemia
Anorexia or Bulimia
Arthritis
Artificial Joints
Artificial Heart Valves
Asthma/Breathing Problems
Blood Disorders/Issues or Blood Transfusion
Cancer / Radiation Treatment
Clotting/Bleeding Problems
Cold Sores
Depression
Diabetes
Drug use/substance abuse
Epilepsy
Fainting
Fibromyalgia
Gastrointestinal Disease
G.E.R.D
Growth or Tumor
Heart Attack/Chest Pain/Angina
Heart Disease
Hepatitis A B C
Hemophilia
High or Low Blood Pressure
HIV/AIDS
Kidney / Liver Problems
Mental/Nervous Disorders
Migraines/Headaches
Organ Transplant
Osteoporosis
Thyroid Problems
Pacemaker/Defibrillator
Rheumatic Fever
Sinus Problems
Sleep Apnea
Snoring
Surgery
Tuberculosis
Ulcers

Is there anything else you would like us to know about your health? _____

Women:
Are you pregnant? Yes No If yes, how many months: _____

Dental History

Purpose of your visit today? _____

Have you ever experienced any of the following?

Does your jaw click or hurt?	◯Yes	Do you smoke or use chewing tobacco?	◯Yes
Do you think you grind your teeth?	◯Yes	Do you ever have bad breath?	◯Yes
Have you ever had orthodontic treatment?	◯Yes	Do your gums bleed when you brush?	◯Yes
Do you wear a night guard?	◯Yes	Do you experience hot/cold sensitivity	◯Yes
Have you ever been told you have gum disease?	◯Yes	Does floss ever tear between your teeth?	◯Yes
Have you ever had your bite adjusted?	◯Yes	Does food get stuck between your teeth?	◯Yes
Do you bite your cheeks or lips often?	◯Yes	Do your teeth hurt when you bite hard?	◯Yes
Does your mouth often seem dry?	◯Yes	Have you ever had issues with freezing? (Local anaesthetic)	◯Yes

Are any of your teeth sensitive or aching? ◯Yes If yes, which tooth or area? _____

When was your last visit to a dental office? _____ Last professional cleaning? _____ Last xrays? _____

Have you ever experienced problems with dental treatments? _____

What is your dental comfort level on a scale from 1 to 10? ☹ 1 2 3 4 5 6 7 8 9 10 ☺

How often do you brush your teeth? _____ How many times per week do you floss? _____

Please circle if you use any of the following: Mouthwash / Toothpicks / Proxy-brush / Floss threaders

Any other condition related to the health of your gums? _____

Rate your smile: ☹ 1 2 3 4 5 6 7 8 9 10 ☺

What would you like to change or improve in your teeth or smile?

_____

_____

Is there anything you would like to make us aware of that has not been covered on this form?

_____

_____

Permission to Treat, Release of Information & Privacy

I hereby authorize the doctor or designated team to take x-rays, study models, diagnostic photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents that is not an insured benefit.

Patient's Signature: _____ Date: _____