DenteVita® PROSTHODONTICS

WELCOME

PATIENT INFORMATION

Date _____
Patient _____
Address _____
City _____
State _____ Zip _____
E-mail _____
Sex ☐ M ☐ F Age _____ Birthdate _____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for years _____
Occupation _____
Patient Employer/School _____
Employer/School Address _____
Employer/School Phone _____
Spouse's Name _____
Birthdate _____
SS# _____
Spouse's Employer _____
Whom may we thank for referring you?
_____

DENTAL INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group# _____

Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber's Name _____
Birthdate _____
SS# _____ Relationship to Patient _____
Insurance Co. _____
Group# _____

ASSIGNMENT AND RELEASE

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home _____ Work _____ Ext. Cell Phone _____
Spouse's Work _____ Best time and place to reach you _____
_____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____
Home Phone _____ Work Phone _____

DENTAL HISTORY

Reason for today's visit _____
_____

Former Dentist _____
City/State _____
Date of last dental visit _____
Date of last dental X-rays _____
Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	Yes ☐ No ☐	Chew on one side of mouth	Yes ☐ No ☐
Bleeding gums	Yes ☐ No ☐	Cigarette, pipe, or cigar smoking	Yes ☐ No ☐
Blisters on lips or mouth	Yes ☐ No ☐	Clicking or popping jaw	Yes ☐ No ☐
		Dry mouth	Yes ☐ No ☐
		Figernail biting	Yes ☐ No ☐
		Food collection between teeth	Yes ☐ No ☐
		Foreign objects	Yes ☐ No ☐
		Grinding teeth	Yes ☐ No ☐
		Gums swollen or tender	Yes ☐ No ☐
		Jaw pain or tiredness	Yes ☐ No ☐
		Lip or cheek biting	Yes ☐ No ☐
		Loose teeth or broken fillings	Yes ☐ No ☐

Mouth breathing	Yes ☐ No ☐
Mouth pain, brushing	Yes ☐ No ☐
Orthodontic treatment	Yes ☐ No ☐
Pain around ear	Yes ☐ No ☐
Periodontal treatment	Yes ☐ No ☐
Sensitivity to cold	Yes ☐ No ☐
Sensitivity to heat	Yes ☐ No ☐
Sensitivity to sweets	Yes ☐ No ☐
Sensitivity when biting	Yes ☐ No ☐
Sores or growths in your mouth	Yes ☐ No ☐

How often do you floss? _____
How often do you brush? _____

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of lonimin, Adipex, Fastin (brand names for phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes ☐ No ☐

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	Yes ☐ No ☐	Emphysema	Yes ☐ No ☐	Respiratory Disease	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Epilepsy	Yes ☐ No ☐	Rheumatic Fever	Yes ☐ No ☐
Arthritis, Rheumatism	Yes ☐ No ☐	Fainting or dizziness	Yes ☐ No ☐	Scarlet Fever	Yes ☐ No ☐
Artificial Heart Valves	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐	Shortness of Breath	Yes ☐ No ☐
Artificial Joints Asthma	Yes ☐ No ☐	Headaches	Yes ☐ No ☐	Sinus Trouble	Yes ☐ No ☐
Back Problems	Yes ☐ No ☐	Heart Murmur	Yes ☐ No ☐	Skin Rash	Yes ☐ No ☐
Bleeding abnormally, with extractions or surgery	Yes ☐ No ☐	Heart Problems	Yes ☐ No ☐	Special Diet	Yes ☐ No ☐
		Hepatitis Type __	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Blood Disease	Yes ☐ No ☐	Herpes	Yes ☐ No ☐	Swollen Feet or Ankles	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐	Swollen Neck Glands	Yes ☐ No ☐
Chemical Dependency	Yes ☐ No ☐	Jaundice	Yes ☐ No ☐	Thyroid Problems	Yes ☐ No ☐
Chemotherapy	Yes ☐ No ☐	Jaw Pain	Yes ☐ No ☐	Tonsillitis	Yes ☐ No ☐
Circulatory Problems	Yes ☐ No ☐	Kidney Disease	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐
Congenital Heart Lesions	Yes ☐ No ☐	Liver Disease	Yes ☐ No ☐	Tumor or growth on head or neck	Yes ☐ No ☐
Cortisone Treatments	Yes ☐ No ☐	Low Blood Pressure	Yes ☐ No ☐		
Cough, persistent or bloody	Yes ☐ No ☐	Mitral Valve Prolapse	Yes ☐ No ☐	Ulcer	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Nervous Problem	Yes ☐ No ☐	Venereal Disease	Yes ☐ No ☐
Do you wear contact lenses?	Yes ☐ No ☐	Pacemaker	Yes ☐ No ☐	Weight Loss, unexplained	Yes ☐ No ☐
		Psychiatric Care	Yes ☐ No ☐		
		Radiation Treatment	Yes ☐ No ☐		

Women:

Are you pregnant: Yes ☐ No ☐ Due date _____ Are you nursing? Yes ☐ No ☐

Taking birth control pills? Yes ☐ No ☐

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

☐ Aspirin
☐ Barbiturates (Sleepingpills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other _____

UPDATES (to be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes ☐ No ☐

For what conditions? _____

Are you taking any new medications? Yes ☐ No ☐ If so,what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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For what conditions? _____

Are you taking any new medications? Yes ☐ No ☐ If so,what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____