CABANA FAMILY DENTAL

PATIENT INFORMATION

Date _____

NAME _____ Married ___ Single___ Partnered___ Male___ Female___

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE (Home) _____ (Work) _____

PHONE (Cell) _____ E-mail _____

BIRTH DATE _____ SS# _____

IF FULL TIME COLLEGE STUDENT, SCHOOL NAME _____

SPOUSE OR PARENT'S NAME _____

PATIENT'S OR PARENT'S EMPLOYER _____

DENTAL INSURANCE COMPANY _____ GROUP # _____

NAME OF SUBSCRIBER _____

SUBSCRIBER SS# _____ SUBSCRIBER DOB _____

Has any member of your family ever been treated in our office? _____

Whom may we thank for referring you to our office? _____

Person to contact in case of emergency _____ Phone _____

MEDICAL HISTORY

Do you see a physician regularly? Yes_____ No _____ If so, why? _____

Physician name _____ Office phone _____ Date of last exam _____

Have you ever been hospitalized or had a major operation? Yes ___ No ___ Discuss _____

Have you ever had a serious injury to your head, neck or mouth? Yes ___ No ___ Discuss _____

***** Have you ever been treated for osteoporosis or osteopenia? Yes (currently) ____ Yes (in the past) ____ No ____**

***** If yes, are you presently taking or have ever taken a bisphosphonate or any medication for osteoporosis or osteopenia?**

Ex: Fosamax (*alendronate*), Fosamax Plus D (*alendronate/cholecalciferol*), Zometa (*zolendronic acid*), Didronel (*etidronate*), Reclast (*zolendrolic acid*), Boniva (*ibandronate*), Actonel (*risedronate*), Aclasta (*zolendronic acid*), Aredia (*pamidronate*), Atelvia (*risedronate*), Skelid (*tiludronate*), Prolia (*denosumab*)

Please explain and/or list which medication:

_____

Please list all MEDICATIONS including prescription, over-the-counter, herbal or holistic remedies, vitamins or minerals:

_____

*****Are you allergic to any medications or substances? Yes____ No ___Please circle:**

Codeine/other painkillers	**Sulfa Drugs**	**Food**	**Fluoride**	**Aspirin/Ibuprofen**
Penicillin/other antibiotics	**Acrylic**	**Latex rubber**	**Nitrous oxide**	
Sedatives/Barbituates	**Metals (gold, stainless steel, nickel)**		**Local Anesthesia (novocaine, etc.)**	
Alcohol	**Other _____**			

WOMAN (PLEASE CHECK)

Pregnant/trying to get pregnant _____ Nursing _____ Oral Contraceptives_____

Are you on hormone replacement therapy? Yes ____ No ____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

The ** questions may require premedication for treatment.

	Y	N		Y	N		Y	N		Y	N
Scarlet Fever**			**High Blood Pressure**			**Mental Health Care**			**Epilepsy/Seizures**		
Heart Murmur**			**Low Blood Pressure**			**Ulcers/Acid Reflux**			**Fainting/Dizziness**		
Rheumatic Fever**			**Asthma/Hay Fever**			**Stomach/Intestinal Disease**			**Hepatitis B, C (Serum)**		
Artificial Heart Valve**			**Sinus Problems**			**Loss of Hearing**			**Hepatitis A (Infectious)**		
Heart Pacemaker**			**Excessive Bleeding**			**Eye Impairments**			**Yellow Jaundice**		
Heart Surgery**			**Hemophilia**			**Glaucoma**			**Liver Disease**		
Mitral Valve Prolapse**			**Bruise Easily**			**Headaches**			**Kidney Disease**		
Artificial Joint**			**Blood Transfusion**			**Marked Weight Change**			**Renal Dialysis**		
Rx Diet Drugs**			**Anemia**			**Hypoglycemia**			**Thyroid Disease**		
Radiation Therapy**			**Leukemia**			**Arthritis/Gout**			**Lyme Disease**		
Chemotherapy**			**Irregular Heart Beat**			**Tumors/Growths**			**Cortisone Medication**		
Diabetes**			**Angina/Chest Pain**			**Emphysema**			**AIDS/HIV Positive**		
Congenital Heart Disorder			**Stroke**			**Difficulty Breathing**			**Sexually Transmitted DIseases**		
Heart Attack/Failure			**Cancer**			**Tuberculosis**			**Drug Addiction**		

Do you have any disease, condition, or problem not listed above that you think we should know about? Yes____ No ____

If yes, please explain:_____

DENTAL HISTORY

Date of last dental visit _____ Date of last full mouth x-rays (20 x-rays or Panoramic) _____

Name of your previous dentist _____ City, State _____

Do you have a specific dental problem? Yes____ No____

How long has it been present? _____

Does dental treatment make you nervous? No____ Slightly____ Moderately____ Extremely ____

Do you snore or have sleep apnea? Yes____ No____

Have you ever been tested for sleep apnea? Yes____No____ Do you wake feeling rested in the morning? Yes____ No____

	Y	N		Y	N
Do your gums bleed while brushing or flossing?			**Do you have frequent headaches?**		
Are your teeth sensitive to hot or cold liquids/foods?			**Do you clench or grind your teeth?**		
Are your teeth sensitive to sweet or sour liquids/foods?			**Do you bite your lips or cheeks frequently?**		
Do you feel pain to any of your teeth?			**Have you ever had any difficult extractions in the past?**		
Do you have any sores or lumps in or near your mouth?			**Have you ever had any prolonged bleeding following extractions?**		
Have you had any head, neck or jaw injuries?			**Do you wear a night guard or retainer?**		
Do you have difficulty in opening, closing, or moving your jaw?			**Have you had any orthodontic treatment?**		
Clicking, popping or difficulty chewing?			**Do you wear dentures or partials?**		
Pain, tenderness, numbness in your jaw?			**Have you ever received oral hygiene instructions regarding the care of your teeth and gums?**		

Have you ever had serious trouble associated with previous dental treatment?

_____

Have you whitened/bleached your teeth? Yes_____ No_____

Do you use tobacco in any form? No _____ If yes, how much _____

How long_____

Did you use tobacco in the past? No_____ If yes, how much _____

How long _____

Do you have a family history of oral cancer? Yes_____ No_____

Do you use candy, mints, or gum throughout the day? Yes_____ No_____

Do you sip soda, juice, coffee or tea throughout the day? Yes_____ No_____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf for all my dependents.

X _____

Signature of patient (or parent if minor)

X _____

Signature of doctor/hygienist