Sunridge Dental Care

Name_____ __ _____ Preferred Nickname_____ Preferred Contact # (_____) _____-_____
First M.I. Last

Age_____ Date of birth ____/____/____ SS#_____-____-_____ Email_____ Home # (_____) _____-_____

Address _____ _____ _____ _____
Street City State Zip

Name of spouse _____ _____ Authorized Emergency Contact _____ Relationship_____ Phone_____
First Last

Current / Former Occupation _____ Hobbies / Activities _____ Dental Insurance? Y N Referred By: _____

Medical History

Do you **now** or have you **ever had** any of the following medical conditions?

Please circle ( ) **any positive responses.**

Physician _____ _____
Name Phone

Heart Disease / Bypass Surgery / Stent
Heart Valve Disorder / Replacement
Artificial Joint _____When?____
High / Low Blood Pressure
Use tobacco? Smoke? ___ packs /day
Liver Disorder / Hepatitis - A, B, C
Osteoporosis / Arthritis
Rapid Weight Change - Eating Disorder
Psychiatric Therapy
TMJ Disorder or Therapy
Cancer_____

Pre-medication prior to dentistry?
Heart Attack or Stroke? When?_____
Diabetes Type I or Type II
Sleep Disorder
Respiratory Disease_____
Stomach Disorder / Ulcers
Herpes / Shingles
Alcohol or Drug Dependency
Nervous Disorder / Epilepsy / Seizures
Frequent Headaches
Radiation or Chemotherapy:_____

Heart Murmur
Pacemaker
Bleeding Disorder
Thyroid Disorder
Kidney Disorder
Parkinson's Disease
Alzheimer's disease
Lupus
HIV + / AIDS
Dry mouth
Currently Pregnant?

Please list any **other** medical condition: _____

Hospitalizations in the last 2 years? For what care? _____

Please list **all current medications**: _____

_____

_____

_____

Please list any **allergies to medications**: _____

Allergies to: **Latex, Metals, Acrylic, Other**_____

Dental History

Current dental health? (poor) 1 2 3 4 5 6 7 8 9 10 (ideal) **Desired?** (poor) 1 2 3 4 5 6 7 8 9 10 (ideal)

Please describe your dental problem or chief complaint._____

_____

_____

Mouth sensitivity to: Heat Cold Biting pressure Sweets Inability to chew properly Swelling Bleeding gums

Concerns about the appearance of your teeth? _____

Would you like whiter teeth? y n Are you concerned about bad breath / mouth odor? y n

If you have ever been diagnosed as having periodontal disease, when? _____ Treatment:_____

Date of last dental visit: _____ Care: _____ Brush ___/ day Floss ___/ day

Any other factors which might affect your dental care at this time? _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence. I affirm that it is my responsibility to inform this office of any changes in my medical status. I have received a copy of this office's Notice of Privacy Practices. I hereby authorize Sunridge Dental Care to take my photograph to be placed in my computer file for identification purposes.

X_____ X_____
Patient's Signature **Date**

Office Use Only:

Patient History reviewed / updated: _____ _____ _____ _____
initial / date **initial / date** **initial / date** **initial / date**

Vita 3D Shade _____ / _____ **Classic Shade:** _____ / _____ **(623) 544-0700** 9/2015