BY DESIGN
Dental Implant Center

General Patient Information

Date: _____

How did you hear about By Design Dental Implant Center? _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire, and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient Full Name: _____

Sex:_____ Date of Birth: _____ SS# or Patient ID: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ (Include area code) Business/Cell Phone: _____ (Include area code)

Email: _____

Occupation: _____ Employer: _____

If you are completing this form for another person, what is your relationship to that person?

Your name: _____ Relationship: _____

EMERGENCY CONTACT

Emergency Contact: _____Relationship: _____

Parent Name (If Minor): _____ Date of Birth: _____

Phone Number: _____

- Do you have any of the following diseases or problems?
  - Active tuberculosis ..... ☐ Yes ☐ No
  - Persistent cough greater than a 3-week duration ..... ☐ Yes ☐ No
  - Cough that produces blood ..... ☐ Yes ☐ No
  - Been exposed to anyone with tuberculosis ..... ☐ Yes ☐ No

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

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Health History

Name: _____

Height: _____ Weight: _____ Age: _____

DENTAL INFORMATION

- Do your gums bleed when you brush or floss? ☐ Yes ☐ No
- Are your teeth sensitive to cold, hot, sweets, or pressure? ☐ Yes ☐ No
- Does food or floss catch between your teeth? ☐ Yes ☐ No
- Is your mouth dry? ☐ Yes ☐ No
- Have you had any periodontal (gum) treatments? ☐ Yes ☐ No
- Have you had any orthodontic (braces) treatment? ☐ Yes ☐ No
- Have you had any problems associated with previous dental treatment? ☐ Yes ☐ No
- Is your home water supply fluoridated? ☐ Yes ☐ No
- Do you drink bottled or filtered water? ☐ Yes ☐ No
  If yes, how often? ☐ Daily ☐ Weekly ☐ Occasionally
- Are you currently experiencing dental pain or discomfort? ☐ Yes ☐ No
- Do you have earaches or neck pains? ☐ Yes ☐ No
- Do you have any clicking, popping, or discomfort in the jaw? ☐ Yes ☐ No
- Do you brux or grind your teeth? ☐ Yes ☐ No
- Do you have sores or ulcers in your mouth? ☐ Yes ☐ No
- Do you wear dentures or partials? ☐ Yes ☐ No
- Do you participate in active recreational activities? ☐ Yes ☐ No
- Date of your last dental exam: _____
- Have you ever had a serious injury to your head or mouth? ☐ Yes ☐ No
  What was done at this time? _____
- Date of last dental X-rays: _____
- What is the reason for your dental visit today? _____
- How do you feel about your smile? _____

MEDICAL INFORMATION

- Are you in good health? ☐ Yes ☐ No
- Has there been any change in your health in the past year? ☐ Yes ☐ No
- Date of last physical exam: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, for what condition? _____
  Physician's full name: _____ Phone: _____
- Have you had any serious illness, operation, or hospitalization in the last 5 years? ☐ Yes ☐ No
  If yes, please explain: _____

ALLERGIES

Are you allergic to or have you had a reaction to:

☐ Sulfa Drugs
☐ Codeine or Other Narcotics
☐ Others: _____
☐ Animals
☐ Food
☐ Local Anesthetics
☐ Aspirin
☐ Penicillin or Other Antibiotics
☐ Barbiturates, Sedatives or Sleeping Pills
☐ Metals
☐ Latex (Rubber)
☐ Iodine
☐ Hay Fever/Seasonal
☐ None

MEDICATIONS

Please list all current medications, including herbal/holistic remedies, aspirin, blood thinners, vitamins or over-the-counter medications: _____

_____

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Health History

Name: _____

Height: _____ Weight: _____ Age: _____

MEDICAL INFORMATION (Cont.)

- Do you wear contact lenses?..... ☐ Yes ☐ No
- Have you ever had an orthopedic total joint (hip, knee, elbow, finger) replacement?..... ☐ Yes ☐ No
  If yes, date: _____ If yes, any complications?_____
- Are you taking or scheduled to begin any of the medications alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?..... ☐ Yes ☐ No
- Since 2001, were you treated or are you presently scheduled to begin with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer?..... ☐ Yes ☐ No
  If yes, date treatment began: _____
- Do you use controlled substances (drugs)?..... ☐ Yes ☐ No
- Do you use tobacco (smoking, snuff, chew, bidis)?..... ☐ Yes ☐ No
  If so, how interested are you in stopping? ☐ Very ☐ Somewhat ☐ Not Interested
- Do you drink alcoholic beverages?..... ☐ Yes ☐ No
  If yes, how much did you drink in the last 24 hours?_____ In the last week?_____
- Do you have or have you ever had any of the following diseases or problems?

☐ Cardiovascular Disease
☐ Angina
☐ Arteriosclerosis
☐ Congestive Heart Failure
☐ Damaged Heart Valves
☐ Heart Attack
☐ Heart Murmur
☐ Low Blood Pressure
☐ High Blood Pressure
☐ Other Congenital Heart Defects
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Rheumatic Fever
☐ Rheumatic Heart Disease
☐ Abnormal Bleeding
☐ Anemia
☐ Blood Transfusion (Date: _____)
☐ Hemophilia
☐ AIDS/HIV Positive
☐ Arthritis
☐ Autoimmune Disease
☐ Systemic Lupus Erythematosus
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Sinus Trouble
☐ Tuberculosis
☐ Cancer/Chemotherapy/Radiation
☐ Chest Pain Upon Exertion
☐ Chronic Pain
☐ Diabetes Type I or II
☐ Eating Disorder
☐ Malnutrition
☐ Gastrointestinal Disease
☐ G.E. Reflux/Persistent Heartburn
☐ Ulcers
☐ Thyroid Problems
☐ Stroke
☐ Glaucoma
☐ Hepatitis, Jaundice, or Liver Disease
☐ Epilepsy
☐ Fainting Spells or Seizures
☐ Neurological Disorder (Specify: _____)
☐ Sleep Disorder
☐ Mental Health Disorder (Specify: _____)
☐ Recurrent Infections (Type: _____)
☐ Kidney Problems
☐ Night Sweats
☐ Osteoporosis
☐ Persistent Swollen Neck Glands
☐ Severe Headaches/Migraines
☐ Severe or Rapid Weight Loss
☐ Sexually Transmitted Disease
☐ Excessive Urination
☐ Other condition doctor should know

- Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?..... ☐ Yes ☐ No
  Name of physician or dentist making recommendation: _____ Phone:_____

FEMALES ONLY:

- Are you pregnant? ..... ☐ Yes ☐ No
- Are you nursing? ..... ☐ Yes ☐ No
- Are you taking birth control or hormonal replacement? ..... ☐ Yes ☐ No

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ Date: _____

COMMENTS FOR COMPLETION BY DENTIST

_____

_____