LaBuwi Crawford Dental Wellness

PATIENT NAME: ____ SEX: ____ DATE OF BIRTH: ____ S.S.# ____

PREFFERED NAME: ____ PHONE: (HOME): ____ (CELL): ____ (WORK): ____

ADDRESS: ____ APT/UNIT NO: ____ CITY: ____ STATE: ____ ZIPCODE: ____

PARENT/SPOUSE'S NAME: ____ DOB: ____ E-MAIL ADDRESS: ____

IN CASE OF EMERGENCY, ____ PHONE NUMBER: ____

WHOM MAY WE THANK FOR REFERRING YOU? ____

Insurance Information

PRIMARY INSURANCE ____ ID# ____ Grp # ____

POLICY HOLDER ____ DATE OF BIRTH ____ S.S# ____

SECONDARY INSURANCE ____ ID# ____ Grp# ____

POLICY HOLDER ____ DATE OF BIRTH ____ S.S# ____

Female only

FEMALES: ARE YOU PREGNANT OR TRYING TO GET PREGNANT? ____ IF SO, DUE DATE: ____ ARE YOU NURSING? ____

ARE YOU TAKING ORAL CONTRACEPTIVES? ____

Are you taking or do you have a history of taking any of the following medications for Osteoporosis, Joint Replacement, Cancer or Paget's disease?

Yes or No (circle one)

If yes, which one?

Fosamax, Actonel, Atelvia, Didronel, Boniva, Reclast, Zometa, Aclasta, Prolia, Fortea

Were you ever treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, Multiple Myeloma or Metastatic cancer?

Circle Yes or No

If Yes, When did treatment begin? ____

Medical History

LIST ANY MEDICATIONS, NOTING REASON, DOSEAGE& FREQUENCY (USE SEPARATE PAGE IF TOO MANY TO LIST); ____

____

DO YOU USE CONTROLLED SUBSTANCES/ PAIN MEDICATIONS? PLEASE LIST: ____

HAVE YOU HAD MAJOR SURGERY OR BEEN HOSPITALIZED IN PAST FIVE YEARS? ____ Reason/ Date: ____

HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY? ____

ARE YOU UNDER A PHYSICIAN'S CARE NOW: ____ IF SO, PLEASE EXPLAIN: ____

PHYSICIAN'S NAME/PHONE NUMBER: ____ DATE OF LAST PHYSICAL EXAM: ____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? ASPIRIN: ______ PENICILLIN: ______ CODEINE: ______ LATEX: ______ METALS: ______

SULFA DRUGS: ______ LOCAL ANESTHESIA: ______ ACRYLIC: ______ FOOD/OTHER ALLERGY: <explain> ______

ARE YOU REQUIRED TO TAKE AN ANTIBIOTIC PRIOR TO DENTAL TREATMENT? ______ IF YES, WHAT FOR? ______

DOES PATIENT HAVE, OR EVER HAD ANY OF THE FOLLOWING? (Please mark yes or no) DO YOU USE TOBACCO PRODUCTS? □Yes □No

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS/HIV POSITIVE	□	□	CORISONE MEDICINE	□	□	HEMOPHELIA	□	□	RADIATION TREATMENTS	□	□
ALZHEIMER'S	□	□	DIABETES	□	□	HEPATITIS A	□	□	RECENT WEIGHT LOSS	□	□
ANAPHYLAX	□	□	DRUG ADDICTION	□	□	HEPATITIS B or C	□	□	RENAL DIALYSIS	□	□
ANEMIA	□	□	EASILY WINDED	□	□	HERPES	□	□	RHEUMATIC FEVER	□	□
ANGINA	□	□	EMPHYSEMA	□	□	HIGH BLOOD PRESSURE	□	□	RHEUMATISM	□	□
ARTHRITIS/GOUT	□	□	EPILEPSY OR SEIZURES	□	□	HIGH CHOLESTEROL	□	□	SCARLET FEVER	□	□
ART.HEART VALVE	□	□	EXCESSIVE BLEEDING	□	□	HIIVES OR RASH	□	□	SHINGLES	□	□
ARTIFICIAL JOINT	□	□	EXCESSIVE THIRST	□	□	HYPOGLYCEMIA	□	□	SICKLE CELL DISEASE	□	□
ASTHMA	□	□	FAINTING /DIZZINESS	□	□	IRREGULAR HEARTBEAT	□	□	SINUS TROUBLE	□	□
BLOOD DISEASE	□	□	FREQUENT COUGH	□	□	KIDNEY PROBLEMS	□	□	SPINA BIFADA	□	□
BLOOD TRANS	□	□	FREQUENT DIARRHEA	□	□	LEUKEMIA	□	□	STOMACH/INTEST DISEASE	□	□
BREATHING PROBLEMS	□	□	FREQUENT HEADACHE	□	□	LIVER DISEASE	□	□	STROKE	□	□
BRUISE EASILY	□	□	GENITAL HERPES	□	□	LOW BLOOD PRESSURE	□	□	SWELLING OF LIMBS	□	□
CANCER	□	□	GLAUCOMA	□	□	LUNG DISEASE	□	□	THYROID DISEASE	□	□
CHEMOTHERAPY	□	□	HAY FEVER	□	□	MITRAL VALVE PROL	□	□	TONSILLITIS	□	□
CHEST PAINS	□	□	HEART ATTACK/FAILURE	□	□	OSTEOPOROSIS	□	□	TUBERCULOSIS	□	□
Cold Sore/Fever Blisters	□	□	HEART MURMUR	□	□	PAIN IN JAW JOINTS	□	□	TUMORS OR GROWTHS	□	□
CONG.HEART DISORDER	□	□	HEART PACEMAKER	□	□	PARATHYROID DISEASE	□	□	ULCERS	□	□
CONVULSIONS	□	□	HEART TROUBLE/DISEASE	□	□	PSYCHIATRIC CARE	□	□	VENEREAL DISEASE	□	□
TROUBLE SLEEPING/	□	□	SNORING	□	□	DIFFICULTY BREATHING			DAYTIME SLEEPINESS	□	□
INSOMNIA			SLEEP APNEA	□	□	WHILE LAYING BACK	□	□	YELLOW JAUNDICE	□	□

LIST ANY CONDITIONS THAT ARE FROM YOUR PAST THAT YOU ARE NOT CURRENTLY BEING TREATED FOR ______

Dental History

WHAT ARE YOUR EXPECTATIONS FOR TODAY'S VISIT? ______

ARE YOU IN ANY PAIN? IF YES PLEASE DESCRIBE: ______

FORMER DENTIST? ______ DATE OF LAST DENTAL VISIT? ______ DATE OF LAST CLEANING AND X RAYS ______

HOW OFTER DO YOU BRUSH? ______ FLOSS? ______

ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? ______

HOW DO YOU FEEL ABOUT YOUR SMILE? ______

DO YOU HAVE ANY REACTIONS TO LOCAL ANESTHETIC? ______ PLEASE DESCRIBE: ______

PLEASE ANSWER YES OR NO FOR THOSE THAT APPLY TO THE YOU

	YES	NO		YES	NO		YES	NO		YES	NO
BAD BREATH	□	□	FOOD COLLECTING BETWEEN	□	□	PERIODONTAL TREATMENT	□	□	PRESSURE	□	□
BLEEDING GUMS	□	□	GRINDING OR CLENCHING	□	□	SENSITIVITY TO HOT	□	□	SENSITIVITY WHEN BITING	□	□
CLICKING OR POPPIN	□	□	LOSE OR BROKEN TEETH	□	□	SENSITIVY TO COLD	□	□	SORES OR GROWTHS IN MOUTH	□	□

DO YOU OR HAVE YOU EVER WORE A DENTURE/PARTIAL? ______ HAVE YOU HAD ORTHODONTIC TREATMENT? ______

ADDITIONAL INFORMATION/COMMENTS: ______

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR THE PATIENT'S) HEALTH: IT IS MY RESPONSIBLITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.

SIGNATURE OF PATIENT/PARENT OR GUARDIAN: ______ DATE: ______