Patient Information

105 Roadrunner Drive Suite #2 Sedona, AZ 86336 Ph# (928)282-2482 www.azbiodds.com

Patient Name:_____ DOB:_____
Street addtress:_____
City/ST:_____ Zip: _____
Phone #:_____Cell Phone #:_____
Email address:_____
Preferred contact method: Call: Yes ( ) No ( ) Text: Yes ( ) No ( ) email: Yes ( ) No ( )
What is your gender identity: Male ( ) Female ( ) Other ( )_____
Are you happy with your smile? Yes ( ) No ( ) DK ( )
What would you like to change about your smile?_____
How did you hear about our office?_____

Responsible party information

Name:_____DOB:_____
Street address:_____
Phone #:_____Cell Phone #:_____
Email address:_____
Preferred contact method: Call: Yes ( ) No ( ) Text: Yes ( ) No ( ) email: Yes ( ) No ( )

_____

Emergency Contact Relationship Ph. Number

_____

Signature of Patient or Guardian Todays date

Patient Medical History

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Medical

Has there been any major changes to your health within the past year? Yes ( ) No ( ) DK ( )
If yes please explain:_____

Are you under the care of a physician or receiving ongoing medical care? Yes ( ) No ( ) DK ( )
Physician Name:_____

Date of your last medical visit:_____

Are you pregnant? Yes ( ) No ( ) DK ( )
If yes, due date?_____

Do you breast feed? Yes ( ) No ( ) DK ( )

Have you had surgery, x-ray treatment, or chemotherapy for a tumor,
Growth, or other condition? Yes ( ) No ( ) DK ( )
If yes, please explain:_____

Dental

Are you having any dental discomfort at this time? Yes ( ) No ( ) DK ( )
If yes, please explain:_____

Have you ever had serious trouble with previous dental work? Yes ( ) No ( ) DK ( )
If yes, please explain:_____

Does dental work make you nervous? Yes ( ) No ( ) DK ( )

Have you had any abnormal bleeding associated with previous extractions?
Surgery, or trauma? Yes ( ) No ( ) DK ( )
If yes, please explain:_____

Date of your last dental visit:_____

How often do you brush your teeth?_____

How often do you floss your teeth?_____

Other

Do you use tobacco or marijuana? Yes ( ) No ( ) DK ( )
What kind:_____ How often:_____

Do you drink alcohol? Yes ( ) No ( ) DK ( )
How often:_____

Do you have any CURRENT/PAST history of substance abuse? Yes ( ) No ( ) DK ( )
If yes, please explain:_____

Patient Medical History

Medications

Are you taking any prescription or over-the-counter (OTC) medications? Yes ( ) No ( ) DK ( )

Please list all medications you are taking (please include prescription and non-prescription medications):

	Medication	Dosage	How often taken	Reason for medication
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

Allergies

Are you allergic to anything? Yes ( ) No ( ) DK ( )

Please list all allergies including reaction:

	Allergy to:	Reaction:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Arizona Biological Dentistry

Patient Medical History

Medical information:

Please check the answer that is right for you "Yes", "No", "DK" (Don't Know.)

Heart & Circulatory Problems:

Heart Attack Yes() No() DK()
If yes, When:_____
High/Low Blood Pressure Yes() No() DK()
Which:_____
Chest Pain (Angina) Yes() No() DK()
Heart Murmurs Yes() No() DK()
Artificial Valves Yes() No() DK()
Other Heart Problems Yes() No() DK()
Comments:_____

Diabetes Yes() No() DK()
Type:_____
Thyroid Problems Yes() No() DK()
Other Gland Problems Yes() No() DK()
Comments:_____

Breathing/Lung Problems:

Hay Fever Yes() No() DK()
Shortness of Breath Yes() No() DK()
Persistent Cough Yes() No() DK()
Positive Test/Treatment
for Tuberculosis Yes() No() DK()
Seasonal Allergies Yes() No() DK()
Asthma Yes() No() DK()
Emphysema Yes() No() DK()
Coughing up Blood Yes() No() DK()
Comments:_____

Stomach Problems:

Stomach Pain Yes() No() DK()
Heartburn Yes() No() DK()
History of Ulcers Yes() No() DK()
Colitis Yes() No() DK()

Mental Health Problems:

Depression Yes() No() DK()
Anxiety Yes() No() DK()
Psychiatric
medication taken Yes() No() DK()
Comments:_____

Muscle & Bone Problems:

Joint/Back Pain Yes() No() DK()
Joint Swelling Yes() No() DK()
Arthritis Yes() No() DK()
History of Joint
Replacement Yes() No() DK()
Comments:_____

Liver:

Hepatitis A, B, C Yes() No() DK()
Liver Disease Yes() No() DK()
Jaundice Yes() No() DK()
Comments:_____

Neurologic Problems:

Epilepsy/Seizures Yes() No() DK()
Headaches Yes() No() DK()
Head Injury Yes() No() DK()
Numbness of your Arms
Legs, Hands, Feet Yes() No() DK()
Stroke Yes() No() DK()
If yes, When:_____
Fainting Spells Yes() No() DK()
Comments:_____

Blood Problems:

Bleeding Problems Yes() No() DK()
Anemia Yes() No() DK()
Hemophilia Yes() No() DK()
Are you taking
blood thinners Yes() No() DK()
If yes, what was
your recent INR level:_____
Comments:_____

Other:

AIDS/HIV Yes() No() DK()
Herpes Yes() No() DK()
Do you Snore Yes() No() DK()
Have you been told that you
have sleep apnea Yes() No() DK()

I understand that, to the best of my knowledge, all of the proceeding answers are true and correct. If I ever have a change in my health or medications, I will inform my healthcare provider immediately.

I hereby give my consent to treatment for myself, or the named patient (of whom I am the parent, legal guardian, or foster parent) to Arizona Biological Dentistry.

_____

Signature of Patient or Guardian Date