AFFORDABLE DENTURES & IMPLANTS®

PATIENT INFORMATION

(FIRST NAME) (MIDDLE NAME) (LAST NAME)

Sex: ____M ___F _____Other DOB: ____/____ /_____ Social Security Number: ___-___-_____

Street Address

City State Zip

Email: _____ Cell: _____ Home: _____

Emergency contact Name and Phone #: _____

Race: African American Asian American Caucasian/White Hispanic Other

Name of Family Physician: _____

Reason for today's visit? _____

Have you received treatment previously in our office? ___Yes ___ No

When? _____

How did you first learn about our affiliated dental practice providing Affordable Dentures?

1. Magazine 2. Newspaper 3. Radio 4.Billboard/Sign 5.Brochure/Mail
6. Television 7. Yellow pages 8. Friend/Relative 9. Internet/Website 10. Other/Doctor

Did you call our toll-free information service (1-800-DENTURE®) Yes No

May we provide your name to denture product companies who wish to send you information about their products? Yes No

May we contact you with information about special offers and new services we may offer at Affordable Dentures? Yes No

If Yes, what is the best way to contact you? ___ Mail ___Phone __Email

Payment Policy

We gladly accept payment by cash, Mastercard, Visa, Discover, Care Credit, and checks with identification. Payment in full is required before beginning any treatment.

PATIENT MEDICAL HISTORY

Name: _____

HEART/BLOOD PRESSURE PROBLEMS

Yes No Rheumatic fever
Yes No Infective endocarditis
Yes No Artificial hear valves
Yes No Congenital heart defect
Yes No Heart murmur
Yes No Mitral Valve Prolapse
Yes No Angina (chest pain)
Yes No Heart Attach, most recent: _____
Yes No Heart Failure
Yes No Coronary heart disease
Yes No High blood pressure
Yes No Low blood pressure
Yes No Palpitations or Arrhythmia (circle)
Yes No Pacemaker
Yes No Implantable defibrillator
Other: _____

RESPIRATORY/LUNG PROBLEMS

Yes No Asthma
Yes No Emphysema/COPD
Yes No Tuberculosis
Yes No Sinusitis
Yes No Bronchitis
Yes No Sleep Apnea
Yes No Snoring
Other: _____

DIABETES/ENDOCRINE DISORDERS

Yes No Diabetes: Type 1 or Type 2 (circle)
If Yes, HbA1C value and date: _____
Yes No Thyroid Problems: Hypo or Hyper (circle)
Other: _____

KIDNEY DISORDERS

Yes No Renal failure/insufficiency
Yes No Dialysis

CANCER OR TUMORS

Yes No Malignant or Benign (circle)
Type and location: _____
Yes No Chemotherapy: past current never (circle)
Yes No Radiation: past current never (circle)
Type and location: _____

NEUROLOGIC/NERVE PROBLEMS

Yes No Stroke, most recent: _____
Yes No TIA (transient ischemic attack)
Yes No Seizures/Epilepsy, most recent: _____
Yes No Multiple Sclerosis
Yes No Parkinson's disease
Yes No Neuropathies
Yes No Dementia/Alzheimer's disease
Yes No Headaches
Yes No Fainting/dizzy spells
Yes No Trigeminal neuralgia
Yes No Feeling of numbness or tingling
Yes No Fibromyalgia
Other: _____

PSYCHIATRIC/MENTAL HEALTH DISORDERS

Yes No Bipolar/Manic depression
Yes No Schizophrenia
Yes No Depression
Yes No Anxiety
Yes No Eating Disorder:_____
Other: _____

BLOOD/HEMATOLOGIC DISORDERS

Yes No Anemia or Sickle Cell disease/trait (circle)
Yes No Hemophilia
Other: _____

STOMACH/INTESTINES/LIVER DISORDERS

Yes No Cirrhosis/chronic hepatitis
Yes No Hepatitis: A B C D (circle)
Yes No Heartburn, acid reflux, GERD
Yes No Ulcers
Yes No Crohn's disease
Other: _____

MUSCLE/BONE/CONNECTIVE TISSUE DISORDER

Yes No Arthritis: Rheumatoid or Osteo (circle)
Yes No Osteoporosis or osteopenia (circle)
Yes No Gout
Yes No Temporomandibular joint disorder
Yes No Lupus
Yes No Joint replacement
If yes, date of location of each: _____
Other: _____

INFECTIOUS DISEASES

Yes No HIV or AIDS (CD4 count: _____)
Yes No Sexually transmitted disease: _____
Yes No Cold Sores
Other: _____

SKIN/HEAD/EYES/EAR/NOSE/THROAT PROBLEMS

Specify: _____

OTHER PROBLEM(S) NOT LISTED ABOVE

Specify: _____

FEMALES ONLY

Yes No Currently pregnant or possibly pregnant
Yes No Currently nursing
Yes No Taking birth control/fertility/hormoes

I certify that the information I have provided on this entire page is accurate and complete to my knowledge.

Signature: _____ *Today's Date:* _____

PATIENT HISTORY INFORMATION

Name: _____

Are you allergic to, have had a reaction to, or are not able to take any of the following?

- Local anesthetics (Novocaine, Lidocaine, Septocaine)
- Peniciliin, Amoxicillin, etc
- Sulfa drugs
- Aspirin
- Codeine or other narcotics
- Metals/ Jewelry (nickel, chrome, etc)
- Iodine
- Latex (rubber)
- Hay fever / seasonal (allergic rhinitis)
- Food/Other: _____

Please specify type of reaction(s): _____

Do you currently or have previously use any of the following substance? Yes No

- Smoke tobacco, #/ day: _____
- Vape / E-cigarettes
- Chew / Dip
- Snuff
- Bidis
- Alcohol, # drinks/ day: _____
- Marijuana
- Other street drugs, prescription drugs, or other substances for recreational purpose, specify: _____

Are you alcohol or drug dependent?

Yes No Don't know

Have you had any teeth extracted recently?

Yes No Don't know

Have you ever had problems with any tooth extractions?

Yes No Don't know

Specify: _____

I certify that the information I have provided on this entire page is accurate and complete to my knowledge.

Signature: _____

Have you taken in the past, currently taking, or scheduled to begin taking any medications for osteoporosis (bisphosphonates)?

- Oral Bisphosphonates: Alendronate (Fosamax, Fosamax Plus HD), Etidronate (Didronel), Ibandronate (Boniva), Risedronate (actonel), Tiludronate (Skelid)
- Intravenous Bisphosphonates: Clodronate (Bonefos), Pamidronate (Aredia), Zolendronic Acid (Reclast, Zometa)
- Prolia (Denosumab)
- Other: _____

Do you take any blood thinners (including Aspirin)?

Yes No Don't know

Specify: _____

Please list all of your current prescription and over-the-counter medications below:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please attach a list if you cannot fit them all in the spaces provided.

Preferred Pharmacy: _____

Address/Location: _____

Phone Number: _____

Date: _____