BioDental Healing

Date _____

Patient Information

Name _____ E-Mail _____
First MI Last

SS# _____ DOB _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Whom may we thank for referring you _____

Person to contact in case of an emergency _____ Phone _____

Patient Medical History

Are you under a physician's care now?	☐ Yes	☐ No	_____
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	_____
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	_____
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	_____
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	_____
Are you on a special diet?	☐ Yes	☐ No	_____
Do you take Premedicate for your dental visits?	☐ Yes	☐ No	_____
Do you use tobacco?	☐ Yes	☐ No	_____
Have you ever taken any Bisphosphonates (XGVEA)?	☐ Yes	☐ No	_____

Please list all prescription and nonprescription medications taken: _____

Women: ☐ Are you Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking Oral Contraceptives

Are you allergic to any of the following: _____

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic Metal	☐ Latex
☐ Local Anesthetics	☐ Sulfa Drugs	☐ Nitrous Oxide	☐ Valium	☐ Demerol
☐ Erythromycin	☐ Tetracycline	☐ Vicodin	☐ Percodan	☐ Other

Have you experienced any of the following in the last 6 months: _____

☐ Chest Pain	☐ Cough	☐ Constipation	☐ Frequent Urinating	☐ Thirst
☐ Fever	☐ Bleeding	☐ Headache	☐ Blurred Vision	☐ Dry Mouth
☐ Night Sweats	☐ Diarrhea	☐ Vomiting	☐ Dizziness	☐ Swollen

Are you taking or have taken any of the following: _____

☐ Recreational Drugs	☐ Acetaminophen	☐ Antibiotics	☐ Antihistamines	☐ Aspirin
☐ Blood Thinners	☐ Blood Pressure Med.	☐ Cold Remedies	☐ Digitalis/Heart Medication	☐ Nitroglycerin
☐ Stericds/ Cortisone	☐ Thyroid Medicine	☐ Tranquilizers	☐ Insulin/Diabetes Drugs	☐ Vitamins

Patient Medical History

Do you have or have had, any of the following:

Y / N		Y / N		Y / N		Y / N	
☐	☐ AIDS/HIV Positive	☐	☐ Convulsions	☐	☐ Hemophilia	☐	☐ Radiation Treatment
☐	☐ Alzheimer's Disease	☐	☐ Cortisone Medicine	☐	☐ Hepatitis A	☐	☐ Recent Weight Loss
☐	☐ Anaphylaxis	☐	☐ Diabetes	☐	☐ Hepatitis B or C	☐	☐ Renal Dialysis
☐	☐ Anemia	☐	☐ Drug Addiction	☐	☐ Herpes	☐	☐ Rheumatic Fever
☐	☐ Angina	☐	☐ Easily Winded	☐	☐ High Blood Pressure	☐	☐ Rheumatism
☐	☐ Arthritis/Gout	☐	☐ Emphysema	☐	☐ Hives or Rash	☐	☐ Sickle Cell Disease
☐	☐ Artificial Heart Valve	☐	☐ Epilepsy of Seizures	☐	☐ Hypoglycemia	☐	☐ Sinus Trouble
☐	☐ Asthma	☐	☐ Excessive Bleeding	☐	☐ Irregular Heartbeat	☐	☐ Intestinal Disease
☐	☐ Blood Disease	☐	☐ Fainting Spells/Dizziness	☐	☐ Leukemia	☐	☐ Swelling of Limbs
☐	☐ Blood Transfusion	☐	☐ Frequent Cough	☐	☐ Liver Disease	☐	☐ Thyroid Disease
☐	☐ Bruise Easily	☐	☐ Frequent Diarrhea	☐	☐ Low Blood Pressure	☐	☐ Tonsillitis
☐	☐ Cancer	☐	☐ Genital Herpes	☐	☐ Lyme Desease	☐	☐ Tuberculosis
☐	☐ Chemotherapy	☐	☐ Hay Fever	☐	☐ Mitral Valve Prolapse	☐	☐ Tumors or Growths
☐	☐ Chest Pain	☐	☐ Heart Attack/Failure	☐	☐ Pain in Jaw Joints	☐	☐ Ulcers
☐	☐ Cold Sores/Fever Blisters	☐	☐ Heart Murmur	☐	☐ Parathyroid Disease	☐	☐ Venereal Disease
☐	☐ Congenital Heart Disorder	☐	☐ Heart Trouble/Disease	☐	☐ Psychiatric Care	☐	☐ Yellow Jaundice

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.
I authorize the dentist to contact my physician.

Physician's Name _____ Phone number _____

Patient Dental History

Reason for This Visit ? _____

When was your last Dental Visit ? _____ What was done then ? _____

Are you experiencing any dental problems now ? ☐ Yes ☐ No _____

Do you clench or grind your teeth? ☐ Yes ☐ No _____

Do you have pain, clicking or popping in your jaw joint ? ☐ Yes ☐ No _____

Do you have any sensitivity to hot, cold, sweets, biting, etc... ☐ Yes ☐ No _____

If you could change anything about your smile, what would you change:

☐ Whiter Teeth ☐ Close Spaces ☐ Straighter Teeth ☐ Repair Chips ☐ Change Shape of Teeth

Have you had any of the following: ☐ Orthodontic Treatment ☐ Periodontal Treatment ☐ Oral Surgery

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the complete of this form. I acknowledge that I have received and read a copy of the Notice of Privacy Practices Sheet and the Financial and Appointment Policy Sheet. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payer and/or healthcare practitioners. I understand that my insurance carrier may pay less than the actual bill for rendered services.
I agree to be responsible for payment of all services rendered on my behalf or my dependents behalf.

Patient's Signature _____ Date _____