287 E Hunt Hwy #101, San Tan Valley, AZ 85143 • (833) 3WISDOM

PATIENT INFORMATION:

Today's Date ____________

First Name ____________ M.I. ______ Last Name ____________ Height ______ Weight ______

Sex: ❑ Male ❑ Female Birth Date ____________ Soc. Sec. # ____________ Employer ____________

Address ____________

City ____________ State ____________ Zip ____________

Home Tel.(____) ____________ Cell.(____) ____________

E-Mail ____________ Hobbies ____________

Referred By ____________ (FIRST NAME) ____________ (LAST NAME) Medical Dr. ____________ (FIRST NAME) ____________ (LAST NAME) Tel. (____) ____________

General Dentist ____________ (FIRST NAME) ____________ (LAST NAME) Dental Specialist ____________ (FIRST NAME) ____________ (LAST NAME)

Has a family member been a patient of our practice? ❑ Y ❑ N; if yes, name and relation ____________

In case of emergency, contact ____________ (FIRST NAME) (LAST NAME) ____________

Tel.(____) ____________ Relation ____________

You may confirm my appointments via *(Please check all that apply)*: ❑ Text ❑ Phone ❑ E-mail

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other ____________

Name ____________ (FIRST NAME) ____________ (LAST NAME) S.S.# ____________ Birth Date ____________

Tel. (____) ____________ Cell. (____) ____________

E-mail ____________

Address (only if different than above) ____________

City ____________ State ____________ Zip ____________

DENTAL INSURANCE:

Primary dental ins. name ____________

Phone (____) ____________

Insured party name ____________ (FIRST NAME) ____________ (LAST NAME)

Insured party ID# ____________

Insured party birth date ____________

Insured party address *(If different than patient)*

____
STREET ADDRESS CITY STATE ZIP CODE

PHARMACY:

MEDICAL INSURANCE:

Primary medical ins. name ____________

Phone (____) ____________

Insured party name ____________ (FIRST NAME) ____________ (LAST NAME)

Insured party ID# ____________

Insured party birth date ____________

Insured party address *(If different than patient)*

____
STREET ADDRESS CITY STATE ZIP CODE

WOMEN ONLY: *(QUESTIONS 1–4)*

Patient's Name ______________________________
FIRST NAME LAST NAME

	Yes	No		Yes	No
1. Is there a possibility of pregnancy?	❏	❏	3. Are you nursing?	❏	❏
2. Expected delivery date? ____________			4. Are you taking birth control pills / injections / devices?	❏	❏

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult with your physician / gynecologist for assistance regarding other methods of birth control.*

Circle All That Apply

DO YOU CURRENTLY HAVE OR EVER HAVE HAD:	YES	NO	NOTES
5. Rheumatic fever?			
6. Damaged heart valves/ mitral valve prolapse?			
7. Heart murmur/ congenital heart defect?			
8. High or low blood pressure?			
9. Heart related chest pain/ angina?			
10. Heart disease/ heart attack(s)? When ________			
11. Irregular heart beat?			
12. Heart surgeries/ pacemaker? When ________			
13. Asthma? Last taken meds?			
14. Emphysema/COPD?			
15. Pneumonia/ bronchitis/ chronic cough?			
16. Sleep Apnea/ loud snoring?			
17. Difficulty breathing / other lung problems?			
18. Smoker? # Packs per day _____ for _____ years			
19. Clots in lungs/ legs? When ___________			
20. Convulsions/ Epilepsy/ Seizures?			
21. TIA's/ strokes?			
22. Fibromyalgia/ muscle disorder?			
23. MS/ myasthenia gravis?			

Circle All That Apply

DO YOU CURRENTLY HAVE OR EVER HAVE HAD:	YES	NO	NOTES
24. Headaches/ migraines/ fainting spells?			
25. Arthritis/ Rheumatoid arthritis?			
26. Extremity numbness/ muscle weakness/ paralysis?			
27. Mental health conditions/ anxiety/ depression?			
28. A history of alcohol/ recreational drugs?			
29. (Low) Hypothyroidism/ (High)Hyperthyroidism?			
30. Hepatitis/ jaundice/ liver disease?			
31. Kidney trouble/ dialysis?			
32. Diabetes? Last blood sugar test # _____ When _______			
33. Stomach ulcers/ acid reflux(GERD)/ IBS?			
34. Total joint replacement? When ____________			
35. History of head and neck radiation?			
36. Osteoporosis/a history of Fosamax, Actonel or other bisphosphonate?			
37. Iron deficiency anemia/ other anemia?			
38. Bleeding tendency/ abnormal bleeding/ take blood thinners?			
39. Eye disease/ Glaucoma?			
40. Do you take any beta blockers? Last dose? ______			
41. Motion/ car sickness?			

Circle All That Apply

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
46. Previous local anesthetics or numbing meds?			
47. Penicillin/ Amoxicillin?			
48. Sulfa drugs?			
49. Aspirin/ Motrin/ other anti-inflammatories?			
50. Codeine/ Morphine/ Demerol other narcotics?			
51. Other medications?			

Circle All That Apply

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
52. Latex?			
53. Sulfites (preservatives in wine or jam)?			
54. Do you have any other known allergies that cause itching, rash, swelling, or difficulty breathing or swallowing?			
55. Have you or any family member had adverse reaction to general anesthesia?			

PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING (INCLUDE DOSAGE OR FREQUENCY IF KNOWN):

Use back for extra space ->

PLEASE LIST ANY PAST SURGERIES AND / OR HOSPITALIZATIONS (INCLUDING THE YEAR PERFORMED)

Use back for extra space ->

I certify that I have read and understand the above questions and to the best of my knowledge, all of the preceding answers are true and correct. If ever there is a change in my health or prescribed medications, I will notify Dr. Fenn.

X ______________________________ X ______________
Signature of patient *(Parent or Guardian if Minor)* **Date**

For office use only: **MP:** I II III IV **TMD:** __________ **ASA:** 1 2 3 4

Reviewed by Dentist: ______________________ **Reviewed by Anesthesia Provider:** ______________________