MegaBiteDental
COSMETIC, IMPLANT, LASER, ORTHODONTIC DENTISTRY

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Patient Information

Today's Date:_____
Email Address:_____

Name:_____
I prefer to be called:_____ ☐Male ☐Female
Birth date: ___/___/___Age:_____SSN:_____
Home Address: _____
_____

☐ Single ☐Married ☐Divorced ☐Widowed ☐Separated
Hm #: (___)_____ Cell #: (___)_____
Wk #: (___)_____ EXT: _____
Best time and place to reach you?_____
Employer: _____
Employer's Address: _____
_____

Whom may we thank for referring you?_____
Other family/friends seen by us:_____

Spouse Information

His / Her Name: _____
Employer: _____
Cell#:(___)_____Wk#:(___)_____
Birth date:___/___/___

Emergency Contact Information

His / Her Name:_____
Relation to Patient: _____
Hm #:(___)_____ Cell#:(___)_____
Wk#:(___)_____ EXT:_____

Dental Insurance

Primary Dental Insurance
Insurance Company Name:_____
Group Plan #:_____
Plan#/Member ID:_____
Insurance Co. Phone #:_____
Are you the subscriber? **Y** **N**

Secondary Dental Insurance:
Insurance Company Name:_____
Group Plan #:_____
Plan#/Member ID:_____
Insurance Co. Phone #:_____
Are you the subscriber? **Y** **N**

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature **Date**

Payment is due in full at time of treatment unless prior arrangements have been approved.

Medical History

How would you rate your current health? ☐ Good ☐Fair ☐Poor

Have you ever taken Phen-Phen? **Y** **N**

Have you ever taken Fosamax / other biphosphonates? **Y** **N**

Are you currently under the care of a physician? **Y** **N**

Physician's name:_____ **Wk#**:(___)_____

Have you ever been told you need to pre-medicate? **Y** **N**

Are you presently taking any prescription/OTC drugs? **Y** **N**

Please list each one**:**_____

_____

Have you had any of the following diseases or medical problems?

Y	**N**	Abnormal Bleeding	**Y**	**N**	Heart Surgery/Pacemaker
Y	**N**	Anemia	**Y**	**N**	Hepatitis – A, B, C
Y	**N**	Artificial bones/joints/valves	**Y**	**N**	High/Low Blood Pressure
Y	**N**	Arthritis	**Y**	**N**	HIV+/AIDS
Y	**N**	Asthma	**Y**	**N**	Hospitalized for any reason
Y	**N**	Blood Transfusion	**Y**	**N**	Kidney Problems
Y	**N**	Cancer/Chemotherapy	**Y**	**N**	Liver problems
Y	**N**	Congenital Heart Defects	**Y**	**N**	Lupus
Y	**N**	Diabetes	**Y**	**N**	Mitral Valve Problems
Y	**N**	Difficulty Breathing	**Y**	**N**	Psychiatric Problems
Y	**N**	Drug/Alcohol Abuse	**Y**	**N**	Radiation Treatment
Y	**N**	Emphysema	**Y**	**N**	Rheumatic /Scarlet Fever
Y	**N**	Epilepsy/Seizures	**Y**	**N**	Shingles
Y	**N**	Fainting Spells	**Y**	**N**	Sinus Problems
Y	**N**	Fever Blisters/Herpes	**Y**	**N**	Stomach Problems
Y	**N**	Glaucoma	**Y**	**N**	Stroke
Y	**N**	Hay Fever/Allergies	**Y**	**N**	Thyroid Problems
Y	**N**	Heart Murmur	**Y**	**N**	Tumors
Other:		_____	**Y**	**N**	Tuberculosis
		_____	**Y**	**N**	Ulcers/Colitis

Are you allergic to any of the following:

Y	**N**	Aspirin	**Y**	**N**	Erythromycin
Y	**N**	Codeine	**Y**	**N**	Tetracycline
Y	**N**	Penicillin	**Y**	**N**	Latex
Y	**N**	Dental Anesthetics	**Y**	**N**	Other**:**_____

Lifestyle Factors

Have you ever smoked? ☐Yes ☐No

If yes – #years:_____ #packs/day:_____

Do you smoke now? ☐Yes ☐No

If yes – #years:_____ #packs/day:_____

Do you use recreational drugs? ☐Yes ☐No

If yes – what types?:_____ frequency:_____

How much alcohol do you drink per week?

#drinks/day_____

How much caffeine do you drink per week?

#drinks/day**:**_____

Women Only

Are you pregnant? ☐Yes ☐No

Are you breastfeeding? ☐Yes ☐No

Are you using a prescribed method of birth control? ☐Yes ☐No

Dental History

What brings you to the office today?

_____

_____

_____

When was your last dental exam?

Date: _____

When were your last dental x-rays taken?

Date:_____

Name of previous dentist:

_____

How often do you floss?

#times/day:_____

How often do you brush?

#times/day:_____

Type of bristles: ☐ Hard ☐ Medium ☐ Soft

Please answer the following questions fully

How would you rate your current dental health?

☐ Good ☐Fair ☐Poor

How would you rate your smile?

☐ Good ☐Fair ☐Poor

Have you been told that you require antibiotics before dental treatment? ☐Yes ☐No

Have you ever had a serious/significant problem with any previous dental work? ☐Yes ☐No

Have you ever had braces? ☐Yes ☐No

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

Have you ever had periodontal treatments (also known as gum treatments?) ☐Yes ☐No

Do you have any of the following:

Y	**N**	Bad Breath	**Y**	**N**	Lesions
Y	**N**	Bleeding Gums	**Y**	**N**	Loose Teeth
Y	**N**	Blisters on Mouth	**Y**	**N**	Migraines
Y	**N**	Broken Fillings	**Y**	**N**	Mouth Pain
Y	**N**	Clicking Jaw	**Y**	**N**	Mouth Sores
Y	**N**	Dentures	**Y**	**N**	Oral Cancer/Lesions
Y	**N**	Difficulty Opening/Closing	**Y**	**N**	Pain
Y	**N**	Difficulty Chewing	**Y**	**N**	Partials
Y	**N**	Dry Mouth	**Y**	**N**	Pain in Jaw
Y	**N**	Ear Pain	**Y**	**N**	Sensitivity to Heat
Y	**N**	Headaches	**Y**	**N**	Sensitivity to Cold
Y	**N**	Sensitivity to Sweets	**Y**	**N**	Sensitivity to Pressure
Y	**N**	Other:	**Y**	**N**	Swollen Gums

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I authorize necessary dental services that I may need with my informed consent.

_____

Signature