



CHANDLER CREEK DENTAL CARE

2200 N AW Grimes Blvd Suite 100

Round Rock, TX 78665-0000

Ph: (512) 609-0066

E-MAIL: chandlercreekdentalcare@gmail.com

Patient Information

Name: _____

Gender: _____

DOB: _____

Phone: _____

Conditions

	Yes	No
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Blood Thinners	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotic Premedication for Dental Work	<input type="checkbox"/>	<input type="checkbox"/>
Heart Stent	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list your medication:		
<hr/>		
Heart Valve Surgery	<input type="checkbox"/>	<input type="checkbox"/>
When was the surgery done?		
Hepatitis / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis Medication	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>
What kind of surgery and when was it done?		
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when was your last seizure?		
<hr/>		
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many heart attacks?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when was your last heart attack?	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV infection	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

Yes No

- Fainting or dizzy spells Yes No
- Emphysema Yes No
- Arthritis Yes No
- Asthma Yes No
- High blood pressure Yes No
- If yes, what was your last blood pressure reading within the last three months? Any other heart trouble that you have been told about? Yes No
- If yes, please list: _____

-
- Hepatitis A Yes No
 - Hepatitis B Yes No
 - Hepatitis C Yes No
 - Lupus Yes No
 - Cold Sores Yes No
 - Blood transfusion Yes No
 - Frequent Headaches Yes No
 - Stomach ulcers Yes No
 - Ankles swell Yes No

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- Mental Health problems Yes No
 - Anorexia/Bulimia Yes No
 - Kidney /Bladder Trouble Yes No
 - Mitral valve prolapse Yes No
 - Gall Bladder trouble Yes No
 - Blood clotting problems Yes No
 - frequent dry mouth/Sjogren syndrome Yes No
 - Cardiac pacemaker Yes No
 - Anemia Yes No
 - ADD,ADHD Yes No
 - Autism Yes No
 - Difficulty Breathing Yes No
 - Blind Yes No
 - Wheelchair bound Yes No
 - Diabetes Yes No
 - If yes, do you take insulin? Yes No
 - If yes, what was your last HbA1c value? _____

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- If yes, have you fainted or passed out in last one year?**
- Heart arrhythmia Yes No
 - Hypertension Yes No
 - High Cholesterol Yes No
 - Cancer Yes No
 - Other Conditions Yes No
 - Allergies:**
 - Allergy to NSAID Yes No
 - Allergy to Erythromycin Yes No
 - Allergy to Dental Anesthetics Yes No
 - Allergy to Metals Yes No
 - Allergy to Latex / Rubber Yes No
 - Allergy to Codeine / Narcotics Yes No
 - Allergy to Sulfa Yes No
 - Allergy to Tetracycline Yes No
 - Allergy to Aspirin Yes No
 - Allergy to Amoxicillin Yes No
 - Allergy to Keflex Yes No
 - Allergic to acrylic Yes No
 - Allergic to nitrous Oxide sedation Yes No
 - Ibuprofen Yes No
 - Other Allergies Yes No

Are you now under the care of a physician? * _____

Physicians name and phone number: _____

Are you in good health? _____

Have you ever had an allergic reaction that interfered with your breathing? Has there been any change in your general health within the past year? * If yes, what condition is being treated?

Have you had a serious illness, operation or been hospitalized in the past 5 years? * If yes, what was the illness or problem? _____

Is there any problem relating to your medical history that has not been mentioned? *
In case of emergency, contact and phone number? *

Are you taking or have you recently taken any prescription (including blood thinners) or over the counter medicine(s)?

Have you ever taken bone density medications such as Fosamax, Boniva, Actonel or any additional medications containing Bisphosphonates? If so, please explain:

If yes, please list all your medications, including vitamins, natural or herbal preparations and/or dietary supplements: *

Are you taking any controlled substances including marijuana? *
Do you use tobacco in any form? If so, please explain. *

FOR FEMALE PATIENTS: {Please select one}

- Are you currently pregnant?
- Are you trying to get pregnant?
- Are you currently nursing?
- Are you taking oral contraceptives?

<u>Yes</u>	<u>NO</u>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Dental Questionnaire

What is the reason for your dental visit today?

Are you currently experiencing dental pain or discomfort?.

If yes, please explain the type of pain and area of mouth:

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

Do you have a Panoramic Xray done in last 5 years?

What factors are most important for your satisfaction with our office?

How do you feel about your smile?

Dental Information

- Do your gums bleed when you brush or floss?
- Are your teeth sensitive to cold, hot, sweets or pressure?.
- Is your mouth dry?
- Have you had any periodontal (gum) treatments?
- Have you ever had orthodontic (braces) treatment?
- Is your home water supply fluoridated?
- Do you have earaches or neck pains?
- Do you have any clicking, popping or discomfort in the jaw?
- Do you grind your teeth?
- Do you have sores or ulcers in your mouth?
- Do you wear dentures or partials?
- Do you participate in active recreational activities?.
- Have you ever had a serious injury to your head or mouth?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>

DENTAL HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED

I CERTIFY THAT THE ANSWERS TO THE HEALTH QUESTIONS ARE ACCURATE AND CORRECT TO THE BEST OF MY KNOWLEDGE. SINCE A CHANGE OF MEDICAL CONDITION OR MEDICATIONS CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT. I UNDERSTAND THAT THE ADMINISTRATION OF LOCAL ANESTHETIC MAY CAUSE AN ADVERSE REACTION OR SIDE EFFECTS, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO BRUISING, HEMATOMA, CARDIAC STIMULATION, TEMPORARY OR RARELY, PERMANENT NUMBNESS, AND MUSCLE SORENESS. I UNDERSTAND THAT AS A RESULT OF DENTAL TREATMENT, INCLUDING PREVENTATIVE PROCEDURES SUCH AS CLEANING AND BASIC DENTISTRY, AS WELL AS FILLINGS OF ALL TYPES, TEETH MAY REMAIN SENSITIVE OR EVEN POSSIBLY QUITE PAINFUL BOTH DURING AND AFTER COMPLETION OF TREATMENT. GUMS AND SURROUNDING TISSUES MAY ALSO BE SENSITIVE OR PAINFUL DURING AND OR AFTER TREATMENT. FOR TREATMENT: I, HEREBY GRANT AUTHORITY TO THE DENTISTS AT CHANDLER CREEK DENTAL CARE TO ADMINISTER ANY TREATMENT OR TO ADMINISTER SUCH ANESTHETICS, ANALGESICS, SEDATIVES AND NITROUS OXIDE SEDATION, AND TO PERFORM SUCH OPERATIONS AS MAY BE DEEMED NECESSARY OR ADVISABLE IN MY DIAGNOSIS AND TREATMENT. I HAVE READ ABOVE TERMS AND CONDITIONS AND CONSENT FOR TREATMENT AND FULLY AGREE TO THEIR CONTENT. I DO VOLUNTARILY ASSUME ANY AND ALL POSSIBLE RISKS, INCLUDING THE RISK OF SUBSTANTIAL AND SERIOUS HARM, IF ANY, WHICH MAY BE ASSOCIATED WITH GENERAL PREVENTATIVE AND OPERATIVE TREATMENT PROCEDURES IN HOPES OF OBTAINING THE POTENTIAL DESIRED RESULTS, WHICH MAY OR MAY NOT BE ACHIEVED, FOR MY BENEFIT.

Patient's / Patient representative's Initials: *

Relationship to patient: *

Self-Parent Guardian

By signing below, I certify that all the above information is true to the best of my knowledge. I understand the importance of this information and that the practice will rely on this information for treating me. I will not hold the practice or any member / staff of the practice, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient or Responsible Party

DATE:
