AFFORDABLE DENTURES & IMPLANTS®

PATIENT HISTORY INFORMATION

Patient ID #

For office use:

Name:_____
(first name) (middle name) (last name)

Sex: ____M____F **Date of Birth:** _____/_____/_____ **Social Security Number:** _____ - _____ - _____

Street Address:_____

City:_____ **State:**_____ **Zip:**_____ **E-Mail:** _____

Home Phone: _____ **Work Phone:** _____ **Cell:** _____

Emergency Contact Name & Phone:_____

Race: ___**African American** ___**Asian American** ___**Caucasian/White** ___**Hispanic** ___**Other**

Name of Family Physician: _____ **City:**_____ **State:**_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

What is your reason for today's visit?_____

1. **Have you received treatment in our office previously?** ❑ YES ❑ NO **If yes, when?** _____
2. **What specific communication led you to choose Affordable Dentures & Implants today?** (check one)

❑ Magazine ❑ Newspaper ❑ Radio ❑ Billboards/Sign ❑ Brochure/Mail ❑ Television
❑ Yellow Pages ❑ Friend/Relative ❑ Internet/Web Site ❑ Other Doctor ❑ Outside Agency

3. **Did you call our toll-free information service (1-800-DENTURE)** ❑ YES ❑ NO
4. **Please sign below to confirm you have read, understand and agree to our Communications Policy.**

Signed: _____ Date: _____

Do you have commercial dental insurance? ❑ YES ❑ NO **Name of insurance:**_____
Speak with our front desk regarding options to utilize your insurance benefits.

Are you currently wearing dentures? ❑ YES ❑ NO **If yes, when did you receive your last dentures?**_____

Have you taken, are you taking or are you scheduled to begin taking medications for osteoporosis?
❑ Oral Bisphosphonates: (Alendronate (Fosamax, Fosamax Plus D), Etidronate (Didronel), Ibandronate (Boniva), Risedronate (Actonel), Tiludronate (Skelid))?
❑ Intravenous Bisphosphonates: (Clodronate (Bonefos), Pamidronate (Aredia) or Zoledronic Acid (Reclast, Zometa))?
❑ Prolia (Denosumab)?

Do you use or have you used tobacco products? (circle Past or Currently per relevant mark)
❑ Smoking (Past/Currently)
❑ Snuff (Past/Currently)
❑ Chew (Past/Currently)
❑ Bidis (Past/Currently)
❑ Vaping (Past/Currently)

Do you drink alcoholic beverages?
❑ YES ❑ NO ❑ DK

If Yes, are you alcohol dependent?
❑ YES ❑ NO ❑ DK

Do you use or have you used prescription or street drugs or other substances for recreational purposes? (circle Past or Currently per relevant mark)
❑ Cocaine (Past/Currently)
❑ Ecstasy (Past/Currently)
❑ Heroin (Past/Currently)
❑ Marijuana (Past/Currently)
❑ Methamphetamine (Past/Currently)
❑ Oxycontin (Past/Currently)
❑ Other:_____ (Past/Currently)

If Yes, are you Drug dependent?
❑ YES ❑ NO ❑ DK

Females only - Are you pregnant?
❑ YES ❑ NO ❑ DK
If yes, how many weeks: _____

Are you nursing?
❑ YES ❑ NO ❑ DK

Are you taking birth control pills, fertility drugs or hormonal replacement?
❑ Birth Control
❑ Fertility Drugs
❑ Hormonal Replacement

Allergies:
Are you allergic to or have you had a reaction to any of the following?
❑ Local anesthetics (Novocaine, Lidocaine)
❑ Penicillin
❑ Sulfa drugs
❑ Aspirin
❑ Codeine or other narcotics
❑ Hay fever/ Seasonal (allergic rhinitis)
❑ Metals/ Jewelry (nickel, chrome)
❑ Iodine
❑ Latex (rubber)
❑ Food/Other:_____

Specify type of Reaction: _____
_____

<CONTINUED>

MEDICATIONS

Are you taking, have you recently (within the last month) taken, or are you supposed to be taking any medications (prescription, over the counter, diet supplements, vitamins, natural or herbal)? ❑ YES ❑ NO ❑ DK

If yes, specify medication(s), dosage and frequency:

Medications Prescription / Over Counter	**Dosage / Frequency**	**Supplements** Diet Supplements, Vitamins (natural or herbal)	**Dosage / Frequency**

Do you take Blood Thinners Daily: ❑ YES ❑ NO ❑ DK If yes, circle: Coumadin Xarelto Plavix Other:_____

Medical Conditions

Heart/Blood Pressure problem
Y N
- ❑ ❑ Rheumatic fever/ Rheumatic heart disease
- ❑ ❑ Infective endocarditis
- ❑ ❑ Artificial heart valves
- ❑ ❑ Congenital heart defect
- ❑ ❑ Heart murmur
- ❑ ❑ Mitral valve prolapse
- ❑ ❑ Angina (chest pain)
- ❑ ❑ Heart attack ~~date of most recent~~
- ❑ ❑ Heart failure
- ❑ ❑ Coronary heart disease
- ❑ ❑ High blood pressure
- ❑ ❑ Low blood pressure
- ❑ ❑ Palpitations
- ❑ ❑ Arrhythmia (irregular heart beat)
- ❑ ❑ Shortness of breath
- ❑ ❑ Swelling of the ankles
- ❑ ❑ Pacemaker
- ❑ ❑ Implantable defibrillator
- ❑ ❑ Other: _____

Respiratory/Lung problem
Y N
- ❑ ❑ Asthma
- ❑ ❑ Emphysema/ COPD
- ❑ ❑ Tuberculosis
- ❑ ❑ Sinusitis
- ❑ ❑ Bronchitis
- ❑ ❑ Persistent Cough
- ❑ ❑ Sleep Apnea
- ❑ ❑ Snoring
- ❑ ❑ Other: _____

Diabetes/Endocrine Disorder
Y N
- ❑ ❑ Diabetes
  Type 1
  Type 2
- ❑ ❑ Thyroid Problems
  Hypothyroidism
  Hyperthyroidism
- ❑ ❑ Other: _____

Kidney/Urinary disorder
Y N
- ❑ ❑ Renal failure/insufficiency
- ❑ ❑ Dialysis
- ❑ ❑ Frequent urination
- ❑ ❑ Other: _____

Cancer or Tumors
Y N
- ❑ ❑ Malignant

Location:_____
_____

- ❑ ❑ Benign

Location:_____
_____

Neurologic/Nerve problem
Y N
- ❑ ❑ Stroke date of most recent
- ❑ ❑ TIA (Transient ischemic attack)
- ❑ ❑ Seizures/Epilepsy
- ❑ ❑ Multiple sclerosis
- ❑ ❑ Parkinson's disease
- ❑ ❑ Neuropathies
- ❑ ❑ Dementia/Alzheimer's (memory loss)
- ❑ ❑ Headaches
- ❑ ❑ Fainting or dizzy spells
- ❑ ❑ Feeling of tingling or numbness
- ❑ ❑ Psychiatric disease/Mental health disorder
- ❑ ❑ Bipolar/Manic depression
- ❑ ❑ Schizophrenia
- ❑ ❑ Depression
- ❑ ❑ ADD/ADHD (attention deficit disorder)
- ❑ ❑ Feelings of anxiety
- ❑ ❑ Feelings of depression
- ❑ ❑ Other: _____

Blood/Hematologic disorder
Y N
- ❑ ❑ Anemia
- ❑ ❑ Sickle cell disease
- ❑ ❑ Sickle cell trait
- ❑ ❑ Bruise easily
- ❑ ❑ Leukemia
- ❑ ❑ Lymphoma
- ❑ ❑ Bleeding disorders
- ❑ ❑ Hemophilia
- ❑ ❑ Other: _____
- ❑ ❑ Other: _____

Stomach/Intestine/Liver disorder
Y N
- ❑ ❑ Cirrhosis/Chronic hepatitis
- ❑ ❑ Jaundice (skin/eyes turn yellow)
- ❑ ❑ Hepatitis: A B C D
  Other: ____ Circle one
- ❑ ❑ Heartburn
- ❑ ❑ Acid reflux (GERDS)
- ❑ ❑ Ulcers
- ❑ ❑ Crohn's disease
- ❑ ❑ Other: _____

Muscle/Bone/Connective Tissue disorder
Y N
- ❑ ❑ Arthritis
  Rheumatoid
  Osteoarthritis
  Other: _____
- ❑ ❑ Osteoporosis
- ❑ ❑ Gout
- ❑ ❑ Temporomandibular joint disorder
- ❑ ❑ Lupus
- ❑ ❑ Fibromyalgia
- ❑ ❑ Joint replacement
- ❑ ❑ Other: _____

Infectious Disease
Y N
- ❑ ❑ HIV
- ❑ ❑ Aids
- ❑ ❑ STD (sexually transmitted disease)
  Syphilis
  Gonorrhea
  Chlamydia
  Genital herpes
  Human papillomavirus
- ❑ ❑ Cold sores
- ❑ ❑ Other: _____

Head/Eyes/Ear/Nose/Throat problem
Y N
- ❑ ❑ Vision problems
- ❑ ❑ Glaucoma
- ❑ ❑ Hearing impairment
- ❑ ❑ Other: _____

Dermatologic/Skin problem
Y N
- ❑ ❑ Specify: _____
_____

Eating disorder
Y N
- ❑ ❑ Bulimia
- ❑ ❑ Anorexia
- ❑ ❑ Other: _____

Do you have any other problem, not listed above?

_____
_____
_____

Is a Medical Consult Necessary:
❑ Yes
❑ No

Patient Name: _____ **Date:** _____/_____/_____

OUR PAYMENT POLICY

We gladly accept payment by cash, MasterCard, Visa and Discover. Some offices are able to accept checks with identification. You will need to check with the office you are visiting to confirm their payment policies.