DESERT BLOOM DENTISTRY

Shawn B. Layton, DMD
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928-428-1617
1475 S. 20th Avenue | Safford, AZ 85546

PATIENT INFORMATION

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address: _____
STREET APT #

_____
CITY STATE ZIP

Phone Mobile _____
Home _____
Work _____

Email _____

Employer _____

Date of Birth _____

Spouse's Name _____

Emergency Contact

Name _____

Phone _____

DENTAL INFORMATION

Reason for today's visit? _____

Do you have any questions or concerns we can help you with today? _____

Do you have dry mouth? _____ If yes, when is it worse? ❒ Morning ❒ Day ❒ Night

Mouth Condition:

Do you have bumps or swelling in your mouth? ❒ Yes ❒ No

Do your gums bleed? ❒ Yes ❒ No

Are your teeth sensitive to hot, cold or sweets? ❒ Yes ❒ No

Do you have an unpleasant taste in your mouth? ❒ Yes ❒ No

Do you get food wedged between your teeth? ❒ Yes ❒ No

If yes, please explain: _____

The following questions relate to headaches caused by the way your teeth come together and the position of your joint. Please check all that are applicable:

❒ Clicking or popping sound in jaw
❒ Wake up with headaches
❒ Drifting or loose teeth
❒ Clenching or grinding teeth
❒ Headaches any time during the day
❒ Ringing, pain, or stuffiness in ear

MEDICAL HISTORY AND INFORMATION

Are you now under the care of a physician? ❒ Yes ❒ No

Physician Name: _____

Phone: _____

Are you in good health? ❒ Yes ❒ No

Has there been any change to your health in the past year? ❒ Yes ❒ No

If yes, what condition is being treated?

_____

Date of last physical exam: _____

Do you have, or have you ever had?

- ❒ Arthritis
- ❒ Asthma
- ❒ Auto-immune Disorder
- ❒ Blood Transfusion
- ❒ Cancer
- ❒ Cortisone / Steroid Therapy
- ❒ Diabetes - TYPE I TYPE II
- ❒ Epilepsy
- ❒ Excessive Bleeding when Cut
- ❒ Fainting Spells / Seizures
- ❒ Glaucoma
- ❒ Heart Murmur
- ❒ Heart Attack
- ❒ Hepatitis
- ❒ LOW / HIGH Blood Pressure
- ❒ HIV Positive
- ❒ Jaundice
- ❒ Kidney Problems
- ❒ Mitral Valve Prolapse
- ❒ Osteoporosis
- ❒ Pacemaker
- ❒ Rheumatic Fever
- ❒ Stroke
- ❒ Tuberculosis
- ❒ Other _____

- ❒ Artificial (prosthetic) Heart Valve
- ❒ Previous Infective Endocarditis
- ❒ Damaged Valves in Transplanted Heart
- ❒ Congenital Heart Disease (CHD)
  - ❒ Unrepaired, Cyanotic CHD
  - ❒ Repaired (completely) in last 6 months
  - ❒ Repaired CHD with residual defects

Except for these conditions, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Joint Replacement -- Have you had on orthopedic total joint (hip, knee, elbow, finger) replacement? _____

Are you taking or scheduled to begin taking either of the medications: alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's Disease? ❒ Yes ❒ No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ❒ Yes ❒ No Date treatment began: _____

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Are you allergic to?
- ❒ Aspirin
- ❒ Local Anesthetics
- ❒ Sulfa Drugs
- ❒ Codeine or Other Narcotics
- ❒ Penicillin or Other Antibiotics
- ❒ Barbiturates, Sedatives, or Sleeping Pills
- ❒ Latex (Rubber)
- ❒ Other _____

Are you taking aspirin or any other blood thinners (Warfarin®, Coumadin®)? ❒ Yes ❒ No

Female Patients
Are you pregnant? ❒ Yes ❒ No
Do you take birth control pills? ❒ Yes ❒ No

What medications are you currently taking? _____
_____
_____
_____

Do you take vitamins or Supplements? ❒ Yes ❒ No
What supplements: _____

Do you use tobacco (smoking, snuff, chew)? ❒ Yes ❒ No
If yes, how interested are you in stopping?
VERY SOMEWHAT NOT INTERESTED

Do you use controlled substances (drugs)? ❒ Yes ❒ No

Do you drink alcoholic beverages? ❒ Yes ❒ No
If yes, how much did you drink the last 24 hours? _____
If yes, how much do you typically drink in 1 week?

INSURANCE

Subscriber Name _____ SSN _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to Patient _____ Do you have any other insurance coverage? _____

Insurance Authorization Statement
I understand that I am responsible for all costs of dental treatment. I hereby authorize Desert Bloom Dentistry to administer such medications and preform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ Date _____

TREATMENT AUTHORIZATION

Before treatment is rendered, adequate radiographs of the teeth and mouth must be taken. I authorize and give consent to perform dental services agreed between doctor and patient and/or guardian to be necessary or advisable including the use of local anesthesia and other medications as indicated. I certify to the above statements regarding my medical condition. I agree to give at least 24 hours notice of cancellation or incur a $25 scheduling fee.

_____ _____
SIGNATURE PATIENT / LEGAL GUARDIAN DATE

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about the above form have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, 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 PATIENT / LEGAL GUARDIAN DATE

FOR COMPLETION BY DENTIST

Comments _____

_____