Sather Family Dental, LLC

SatherFamilydDental.com
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Phone: 715-859-2202

Patient Name: _____ _____ _____
Last **First** **MI**

Preferred Name: _____

Emergency Contact: Name: _____

Phone Number: _____

Have you had any major MEDICAL CARE or surgeries in the past two years?

- ◯ No
- ◯ Yes (Please Explain): _____

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva, or similar drugs?

- ◯ No
- ◯ Yes

Have you ever noticed any sensitivity to metals in jewelry or dental materials?

- ◯ No
- ◯ Yes

Please list any ALLERGIES to substances or medications: _____

_____

_____

Please list any prescribed MEDICATIONS or over the counter medications or herbal supplements that you are currently taking: _____

_____

_____

Indicate which of the following you have HAD or HAVE at present.

PLEASE CHECK ALL THAT APPLY:

- ◯ Heart surgery, disease, or attack
- ◯ Heart murmur
- ◯ Artificial heart valve/Pacemaker
- ◯ Cortisone medicine
- ◯ Ulcers
- ◯ Glaucoma
- ◯ Chronic cough
- ◯ Radiation therapy
- ◯ Hepatitis A, B, or C
- ◯ Blood transfusion
- ◯ Epilepsy or Seizures
- ◯ Psychiatric/ Psychological care
- ◯ High/Low Blood Pressure
- ◯ Rheumatic Fever
- ◯ Artificial Joints (hip/knee)
- ◯ Diabetes
- ◯ Contact lenses
- ◯ Tuberculosis
- ◯ Latex Sensitivity
- ◯ Chemotherapy
- ◯ A.I.D.S/HIV Positive
- ◯ Hemophilia
- ◯ Liver disease/ Jaundice
- ◯ Fainting/Dizzy spells
- ◯ Congenital Heart Disease
- ◯ Arthritis/Rheumatism
- ◯ Stroke
- ◯ Kidney Trouble
- ◯ Thyroid Problems
- ◯ Emphysema
- ◯ Asthma
- ◯ Sinus Trouble
- ◯ Cold sores/Fever Blisters
- ◯ Sickle Cell disease
- ◯ Neurological disorders
- ◯ Nervous/Anxious
- ◯ Pregnant (Currently)
- ◯ Use prescribed birth control

Physician's Name/Address: _____

_____

Please explain any other disease, conditions, or problems not listed that we need to be made aware of:

_____

_____

DENTAL HISTORY

Date of last full mouth x-rays: _____

What was the date of your last cleaning? _____

Previous Dentist's Name/Address: _____

_____

How often do you brush your teeth?

- ◯ Rarely
- ◯ Once a day
- ◯ Twice a day
- ◯ More than twice

How often do you floss your teeth?

- ◯ Rarely
- ◯ 1-3 times per week
- ◯ More than 4 times per week

Have you ever used, or are you currently using topical Fluoride?

- ◯ No
- ◯ Yes

Are you satisfied with the appearance of your teeth?

- ◯ No (Please Explain) _____
- ◯ Yes

Are any of your teeth sensitive to:

- ◯ Hot or Cold
- ◯ Sweets
- ◯ Biting or Chewing

Details: _____

_____

Have you ever had:

- ◯ Orthodontic treatment (Braces/Invisalign)
- ◯ Periodontal treatment (Gum Disease)
- ◯ A bite plate or mouthguard
- ◯ Oral Surgery
- ◯ Teeth extracted
- ◯ Your teeth ground or bite adjusted
- ◯ Serious injury to the mouth or head

Do you: (Check all that apply)

- ◯ Notice any mouth odors or bad tastes
- ◯ Frequently get cold sores, blisters, or any other oral lesions
- ◯ Have gums bleed or hurt
- ◯ Clench or grind your teeth while awake or asleep
- ◯ Bite your lips or cheeks regularly
- ◯ Snore or have any other sleep disorders
- ◯ Smoke/chew tobacco or use tobacco products
- ◯ Have a history of gum disease or tooth loss in yourself or family
- ◯ Have any loose teeth
- ◯ Notice a change in your bite
- ◯ Have food caught often between your teeth
- ◯ Regularly play contact sports, where a mouthguard may provide protection

Please explain any oral surgery you have had: _____

_____

Have you Experienced:

- ◯ Clicking or popping of your jaw
- ◯ Difficulty in opening/closing mouth
- ◯ Headaches, neckaches, or shoulder aches
- ◯ Pain in jaw, ear, or side of face
- ◯ Difficulty in chewing on either side of the mouth
- ◯ Tired jaw, especially in the morning

Have you ever been told to take a PRE-MEDICATION (antibiotic) prior to dental treatment?

- ◯ No
- ◯ Yes – Name of Rx _____

Is there anything else about having dental treatments that you would like us to know?

_____

_____

_____

What is the Primary Reason for today's visit?

_____

_____

_____

What/Who helped you decide to come to Sather Family Dental?

_____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health and medications.

X _____

(First name – Last name)

_____

(Relationship- if Minor)

Date: _____