PATIENT NAME: _____ ***DATE:*** _____

MEDICAL HISTORY

Physician Name: _____ Phone: _____

Date of last physical exam: _____ Are you under the care of a physician now? ❒ **YES** ❒**NO**

If **yes**, please explain: _____

Have you ever been hospitalized, and if so for what? _____

CIRCLE any of the following conditions you have or have had in the past:

Heart Failure	Artificial Joints/Prosthesis	Fainting/Dizzy Spells	Hay Fever
Heart Disease or Attack	Anemia	Nervousness	Sinus Trouble
Chest Pain	Stroke	Depression	Allergies/Hives
High Blood Pressure	Kidney Trouble/Disease	Psychiatric Treatment	Diabetes
Heart Murmur	Hepatitis	Sickle Cell Disease	Thyroid Disease
Mitral Valve Prolapse	Liver Disease	Glaucoma	Arthritis
Rheumatic Fever	Yellow Jaundice	Chemotherapy	Cortisone Medicine
Heart Defects	Blood Transfusion	(Cancer/Leukemia)	Pain in Jaw Joints
Scarlet Fever	Drug Addiction	Venereal Disease	HIV Positive
Artificial Heart Valve	Hemophilia	Bruise Easily	AIDS
Heart Pacemaker	Fever Blisters	Emphysema	Loss of Appetite
Heart Surgery	Epilepsy or Seizures	Asthma	Loss of Sleep
Osteoporosis			

CIRCLE any of the following medications you are allergic to or that have caused reactions:

Aspirin	Local Anesthetic (Novocain)	Valium
Nitrous Oxide	Codeine	Penicillin
Percodan	Erythromycin	Sulfa

List any other medications that you are knowingly allergic to or have had a bad reaction to: _____

List any medications you are currently taking: _____

Are you currently, or have you ever taking the drug **Fen Phen**? ❒ **YES** ❒ **NO**

Are you currently **pregnant**, trying to get pregnant, or **nursing**? (PLEASE CIRCLE) ❒ **YES** ❒ **NO**

Are you currently taking Birth Control Pills? ❒ **YES** ❒ **NO**

Are you taking any medications for **osteoporosis**? ❒ **YES** ❒ **NO**

Is there any other medical information not included above which you feel we should be informed about? ❒ **YES** ❒ **NO**

If **yes**, please explain: _____

DENTAL HISTORY

1. What prompted you to seek dental care at this time? _____
2. How long has it been since your last thorough dental examination? _____
3. When were your teeth last cleaned? _____ X-rayed? _____
4. Has the fear of discomfort kept you from regular dental visits? _____
5. Are you satisfied with your past dentistry? _____
6. Have you had any bad experiences in a dental office? _____
7. Are you troubled with bad breath? _____
8. Do your gums bleed easily, feel tender or irritated? _____
9. Have you ever been treated for gum disease? _____
10. Are your teeth sensitive to hot, cold or sweets? _____
11. Do you often have sores or fever blisters in your mouth? _____
12. Are there areas in your mouth where food sticks or gets caught? _____
13. Are you self-conscious about the appearance of your teeth? _____
14. Do your jaws often feel tired or sore? _____ If yes, when do you notice this feeling? _____
15. Do you experience excessive headaches and/or pain in the neck, shoulders or back? _____
16. Do you experience clicking or popping noises when opening or closing your mouth, or when chewing food? _____
17. Are you aware of grinding or clenching your teeth? _____
18. Do you smoke? _____ If yes, how much? _____
19. **What, if anything, would you do to change the appearance of your teeth?** _____

CONSENT

I acknowledge that all of the above information is accurate to the best of my knowledge. I hereby authorize Dr. Jesse F. Head, Dr. David T. Madder and/or the trained staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize Dr. Jesse F. Head, Dr. David T. Madder, and/or the trained staff to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents will be used when indicated and that this embodies a certain risk. I hereby give my permission to release any medical/dental information which may be indicated to process insurance claim forms or to receive proper treatment from other health specialists.

_____ _____ _____

Signature of Patient / Parent or Guardian | Dr. Signature | Date

Sonoran Vista Dentistry

Jesse F. Head, DMD

David T. Madder, DMD

PATIENT INFORMATION

Patient Name: Dr. Mr. Mrs. Ms. Miss _____

By what name do you prefer to be called? _____

Date of Birth: _____ **Social Security No:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Mailing Address if different that above: _____

Home Phone Number: _____ **Work Phone Number:** _____

Cell Phone Number: _____ **E-mail Address:**_____

Name of Employer: _____

If full time student, name & location of school: _____

Name of person responsible for account: _____**Phone Number:** _____

Address (if different from above): _____

Name of Spouse: _____ **Phone Number:** _____

Spouse's Employer: _____**Employer Phone Number:** _____

Emergency Contact Person: _____

Relationship: _____ **Phone Number:** _____

Nearest Relative Not Living With You: _____

Relationship: _____ **Phone Number:** _____

How were you referred to our office? _____

INSURANCE INFORMATION

First Insurance Company _____**Effective Date:**_____
Subscriber Name: _____**Employer:**_____
SSN/ID #:_____ **Birthdate:**_____
Group # / Policy #:_____
Relationship to Patient: _____**Self** _____**Spouse** _____**Child** _____**Other**

Second Insurance Company _____**Effective Date:** _____
Subscriber Name: _____**Employer:** _____
SSN/ID #:_____ **Birthdate:** _____
Group # / Policy #: _____
Relationship to Patient: _____**Self** _____**Spouse** _____**Child** _____**Other**

(PLEASE COMPLETE THE BACK SIDE OF THIS FORM)