# Lavender
DENTAL GROUP

## Patient Personal Information

Title _____ Preferred Name _____
Last, First _____ _____ _____
Address _____
_____
City, State, Zip _____
Email _____
Health Care Guardian Name _____
Health Care Guardian Phone # _____

Birth Date _____ Age _____
Marital Status _____ Sex _____
Home # _____ Work # _____
Cell # _____ Drive Lic _____
Emergency Contact _____ Emergency Phone # _____
Student _____ SSN _____
School Name _____
Referral Type _____

## Person responsible/guarantor for paying bills

Title _____ Preferred Name _____
Last, First _____
Address _____
_____
City, State, Zip _____
Email _____

Birth Date _____ Age _____
Marital Status _____ Sex _____
Home # _____ Work # _____
Cell # _____ Drive Lic _____
SSN _____

## Do you have Primary Dental Insurance? __ Yes __ No

Group No/Name _____
Insurance Name _____
Phone # _____
Employer Name _____
Subscriber Last, First _____
Subscriber Address _____
City, State, Zip _____
Relationship to Patient _____ Birth Date _____
Subscriber ID _____

## Do you have Secondary Dental Insurance? __ Yes __ No

Group No/Name _____
Insurance Name _____
Phone # _____
Employer Name _____
Subscriber Last, First _____
Subscriber Address _____
City, State, Zip _____
Relationship to Patient _____ Birth Date _____
Subscriber ID _____

## Patient Medical Information

**Allergies**

- ☐ Y ☐ N Local Anesthetics/Epi
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Sleeping Pills
- ☐ Y ☐ N Metals
- ☐ Y ☐ N Latex
- ☐ Y ☐ N Other (Specify Below)

**Medical Conditions:**

- ☐ Y ☐ N Breathing Problems
- ☐ Y ☐ N Cancer
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Chronic Pain
- ☐ Y ☐ N Congenital Heart Defect
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Epilepsy/Fainting Spells
- ☐ Y ☐ N Gall Bladder Trouble
- ☐ Y ☐ N Headaches/Migraines
- ☐ Y ☐ N Hearing Loss
- ☐ Y ☐ N Heart Attack or Disease
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Heart Stent
- ☐ Y ☐ N High/Low Blood Pressure
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Kidney Disease
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Lump/Swelling in Mouth
- ☐ Y ☐ N Mental Health Issue
- ☐ Y ☐ N Osteoporosis/Osteopenia
- ☐ Y ☐ N Pacemaker
- ☐ Y ☐ N Radiation Treatment
- ☐ Y ☐ N Scarlet Fever
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Sleep Disorder
- ☐ Y ☐ N STD or HPV
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Thyroid Disease
- ☐ Y ☐ N Tubreculosis
- ☐ Y ☐ N Vertigo
- ☐ Y ☐ N Vision Loss

**Check, if applicable**

- ☐ Y ☐ N Pregnant
- ☐ Y ☐ N Premedication Required
- ☐ Y ☐ N Taking Blood Thinners
- ☐ Y ☐ N Abnormal Bleeding
- ☐ Y ☐ N AIDS/HIV Infection
- ☐ Y ☐ N Alcohol/Drug Abuse
- ☐ Y ☐ N Alzheimer's/Dementia
- ☐ Y ☐ N Anorexia/Bulimia
- ☐ Y ☐ N Anxiety/Depression
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Artificial Heart Valve
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Autoimmune Disease
- ☐ Y ☐ N Bladder Trouble
- ☐ Y ☐ N Blood Disorder

**Additional Comments**

## Dental Questionnaire

### Dental Questionnaire

Referred by _____

Approximate date of your last dental visit _____

Do you have an immediate dental concern ? _____

### Personal history

Are you fearful of dental treatment ? How fearful on a scale of 1 to 10 ? _____

Have you had an unfavorable dental experience ? _____

Have you ever had trouble getting numb or had any reactions to local anesthetic ? _____

Have you ever had orthodontic treatment ? _____

Have you had any head, neck or jaw injuries ? _____

### Gum and Bone

Do your gums bleed or are they painful when brushing or flossing ? _____

Any personal history of being treated for gum disease or experience with scaling and root planing ? _____

Do you have an unpleasant taste or odor in your teeth/mouth ? _____

Any family history of periodontal (gum) disease ? _____

Have you ever experienced gum recession, or can you see more of the roots of your teeth ? _____

### Tooth structure

Have you needed any new dentistry within the past 3 years ? _____

Do you have dry mouth ? _____

Are your teeth sensitive to hot, cold or sweets ? _____

Do you frequently get food caught between any teeth ? _____

### Bite and Jaw Joint

Do you have problems with your jaw joint ? (pain, sounds, limited opening, locking, popping) _____

Do you clench or grind your teeth ? _____

Do you wear or have you ever worn a bite appliance ? _____

### Additional Comments

Is there anything about the appearance of your teeth you would like to change? _____

Additional comments: _____

## Medical Questionnaire

### High Important Questionnaire

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) _____

Have you ever taken the diet control drug Fen-Phen? _____

Are you on any Blood Thinners currently (including aspirin)? If so, which: _____

If allergic to any antibiotics, please describe history and symptoms: _____

If you have had a joint replacement, when and where was your surgery performed: _____

Do you need to be pre-medicated with an antibiotic for dental appointments? _____

**Medical Questionnaire**

Any Disease, Condition or Problem not Listed ? Please list _____

Any changes since your last visit? _____

Are you currently taking any medication ? If yes, please list _____

Medication List Continued _____

Are you currently under care of a Physician ? _____

Name of Physician? _____

Have you been hospitalized in the past 5 years? If yes, for what? _____

What is your preferred pharmacy? _____

**Sleep Apnea**

Have you ever been diagnosed with Sleep Apnea _____

Do you sleep with a CPAP machine or Sleep Appliance? _____

**Tobacco/Marijuana Use**

Are you currently a tobacco user? What type? _____

If yes, have you tried to quit? _____

Do you use recreational marijuana? _____

**Women Only**

Are you pregnant? If yes, what is your due date? _____

Are you currently nursing? _____

Are you on birth control/fertility drugs? _____

**Permission**

May we send you special offers, services or other marketing information? You may opt out at any time _____

By signing below, I certify that all of the above information is true to the best of my knowledge.

_____ _____

**Patient/Guardian Signature** **Date**

_____ _____

**Dentist Signature** **Date**