AZ Family Dental

☐ North Phoenix ☐ Cave Creek ☐ Glendale

Patient Personal Information

Name: _____ _____ (LAST / FIRST)

Title: _____ Preferred Name: _____

Address: _____

City, State, Zip: _____

Email: _____

SSN: _____

Health Care Guardian Name: _____

Health Care Guardian Phone: _____

Birth Date: _____ Age: _____

Marital Status: _____ Sex: _____

Home #: _____ Work #: _____ Cell #: _____

Emergency Contact: _____ Emergency #: _____

Emergency Contact Relationship to Patient: _____

How did you hear about us? _____

Person Responsible/Guarantor for Paying Bills

Name: _____ _____ (LAST / FIRST)

Title: _____ Preferred Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Birth Date: _____ Age: _____ Sex: _____

Home #: _____ Work #: _____ Cell #: _____

Patient Medical Information

Allergic to:

- ☐ Y ☐ N Known Allergies
- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Barbiturates/ Sleeping Pills
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals
- ☐ Y ☐ N Epinephrine
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Other Narcotics

Check, if applicable:

- ☐ Y ☐ N Arteriosclerosis
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Autoimmune Disease
- ☐ Y ☐ N Bladder Trouble
- ☐ Y ☐ N Blood Thinners
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Bronchitis
- ☐ Y ☐ N Cancer/Tumor or Growth/Leukemia
- ☐ Y ☐ N Cardiovascular Disease
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Chest Pain Upon Exertion
- ☐ Y ☐ N Congenital Heart Defect
- ☐ Y ☐ N Frequently Dry Mouth/Sjogren
- ☐ Y ☐ N Gag Reflex
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart Disease
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Hepatitis
- ☐ Y ☐ N Herpes
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Kidney Disease
- ☐ Y ☐ N Premedicate
- ☐ Y ☐ N Radiation Treatment
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N Unusual Weight Loss
- ☐ Y ☐ N No Change Since Last Recorded
- ☐ Y ☐ N Abnormal Bleeding
- ☐ Y ☐ N AIDS/HIV Infection
- ☐ Y ☐ N Alcohol/Drug Abuse
- ☐ Y ☐ N Angina
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Ankles Swell
- ☐ Y ☐ N Anorexia/Eating Disorder
- ☐ Y ☐ N Congestive Heart Failure
- ☐ Y ☐ N Artificial Heart Valve
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Epilepsy/Seizures

Patient Medical Information (continued)

Check, if applicable:

☐ Y ☐ N Fainting Spells	☐ Y ☐ N Liver Disease	☐ Y ☐ N Mitral Valve Prolapse
☐ Y ☐ N Fever Blisters	☐ Y ☐ N Low Blood Pressure	☐ Y ☐ N Osteoporosis
☐ Y ☐ N Frequent Headaches	☐ Y ☐ N Anxiety/Depression	☐ Y ☐ N Pacemaker

Other:

☐ Y ☐ N See Scanned Documents: Pt Note

Please note any conditions you may have that are not listed above: _____

Primary Dental Insurance

Insurance Name: _____

Group No/Name: _____

Employer Name: _____

Subscriber Name: _____ _____
LAST FIRST

Subscriber ID: _____

Subscriber Address: _____

City, State, Zip: _____

Relationship to Patient: _____ Birth Date: _____

Secondary Dental Insurance

Insurance Name: _____

Group No/Name: _____

Employer Name: _____

Subscriber Name: _____ _____
LAST FIRST

Subscriber ID: _____

Subscriber Address: _____

City, State, Zip: _____

Relationship to Patient: _____ Birth Date: _____

Dental Questionnaire

Name of previous dentist: _____ Previous dentist phone: _____

Date of your last cleaning: _____ Last exam date: _____

Date of your last full series x-rays: _____ Date of last cavity detection (bitewing) x-rays: _____

Do your gums bleed while brushing or flossing? _____ Are your teeth sensitive to hot, cold or sweets? _____

Have you ever had burning of the tongue? _____ Have you ever had cracking of the corners of your mouth? _____

Do you chew/smoke tobacco in any form? _____ Have you had any head, neck or jaw injuries? _____

Do you clench or grind your teeth? _____ Do you regularly use dental floss? _____

Do you wear dentures or partials? _____ If yes, date of placement of dentures? _____ Are you happy with your dentures? _____

Are you having any specific problems with your teeth, gums, or mouth at this time? _____

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears? _____

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth? _____

Do you have, or have you ever been told, that you have Periodontal Disease? _____

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

Do you have difficulty in opening your mouth widely? _____ Does food catch between your teeth? _____

Any disease, condition or problem not listed? Please list: _____

Dental Questionnaire (continued)

Are you happy with your smile? _____ Are you interested in whitening? _____

Are you interested in straightening your teeth? _____

Would you like information on changing the size and/or shape of your teeth? _____

Medical Questionnaire

Primary care physician: _____ Primary care physician phone: _____

Are you currently under care of a physician? _____ If yes, what is the condition being treated? _____

Have you had any serious illness, operation or been hospitalized within the past 5 years? _____

If yes, what illness or problem? _____

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

Have you taken bisphosphonates? (Bone vitamins) _____ Do you take any blood thinners? _____

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

Do you use alcoholic beverages? _____ Do you smoke and/or vape? _____

Women Only

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

Are you on hormone replacement therapy? _____ Are you on birth control pills/fertility drugs? _____

Additional Comments

Any disease, condition or problem not listed? Please list: _____

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

_____ _____

Patient/Guardian Signature Date

AZ FAMILY DENTAL