



Patient Details (pt #62)

Title:
First Name: **Test**
Last Name: **Test**
Preferred Pronouns:
Date of Birth:
1/1/1888
Age: **138**
Sex at Birth:

Miscellaneous #1:
Miscellaneous #2:

Additional Information

Work Address:
Country: United States
Address Line 1:
Address Line 2:
City:
:
Zip/Postal Code:

Personal Preferences

Communication

You can contact patient via following means:

- ✓ **Contact me on the phone numbers provided**
- ✓ **Leave voicemail at home**
- ✓ **I agree that the dental practice may communicate with me electronically at the email address I provided. I am aware that there is some level of risk that third parties might be able to read unencrypted emails.I am responsible for providing the dental practice any updates to my email address.**

Contact Information

Patient's Address:
Country: United States
Address Line 1:
Address Line 2:
City:
:
Zip/Postal Code:
Marital Status:

Spouse Information

Work Address:
Country: United States
Address Line 1:
Address Line 2:
City:
:
Zip/Postal Code:

Referring

Family File

Head of Household (One HOH per family)

▼

Emergency Contact

Care Team Providers

None

✓ By opting in, I agree to receive SMS messages from the dental office regarding appointment reminders, confirmations, updates, and important office information. Message frequency may vary. Reply STOP to unsubscribe. Msg & data rates may apply.

Confirmation

Patient prefers to receive a reminder before his/her appointment:

Yes, it is a helpful reminder

✓ Receive Email Campaign

Credit Card

None registered

Assignment & Release:

Assignment & Release: Not Signed

Photography Release: No

Social Media Release: No

Bank Account

None registered

Release Information



ASA Risk:

General Information

What is your estimate of your general health?
Date of most recent physical examination:
Purpose:

Physician name:
Physician specialty:

Do you have or have you ever had:

Are you?

Other Questions

Medication List

Supplements & Vitamins



General Information

What is your estimate of your general health?

Physician name:

Date of most recent physical examination:

Physician specialty:

Purpose:

Do you have or have you ever had:

1. Hospitalization for illness or injury

not answered
2. An allergic or bad reaction to any of the following

not answered
- / Aspirin / Ibuprofen / Acetaminophen / Codeine / Penicillin / Erythromycin
- / Tetracycline / Sulfa / Local anesthetic / Fluoride / Chlorhexidine / Latex / Nickel / Gold
- / Silver / Titanium / Nuts / Fruit / Milk / Red dye / Other
3. Heart problems, or cardiac stent within the last six months

not answered
- / Within the last 6 months / Over 6 months with no symptoms
- / Over 6 months with symptoms (angina, shortness of breath)
4. History of infective endocarditis

not answered
5. / Artificial heart valve / Repaired heart defect (PFO)

not answered
6. / Pacemaker / Implantable defibrillator / Organ transplant

not answered
7. Orthopedic or soft tissue implant (e.g., joint replacement)

not answered
8. / Heart murmur / Rheumatic fever / Scarlet fever

not answered
9. High or low blood pressure

not answered
10. Strokes

not answered
- / Within the last 6 months / Over 6 months
11. / Anemia / Other blood disorder

not answered
12. Taking blood thinners

not answered
13. Prolonged bleeding due to a slight cut (INR > 3.5)

not answered
- / Past condition / Ongoing condition
14. / Pneumonia / Emphysema / Shortness of breath while sitting without activity

not answered
- / Sarcoidosis
15. / Chronic ear infections / Tuberculosis / Measles / Chicken pox

not answered
16. Asthma and other breathing problems

not answered
- / Asthma with occasional use of oral inhaler / Asthma with frequent attacks
- / Nasal breathing / Stuffy nose / Sinus congestion
17. Sleep problems

not answered
- / Sleep apnea / Snoring / Insomnia / Restless sleep / Bedwetting
18. / Liver disease / Jaundice

not answered
19. Vertigo (e.g. "the room is spinning")

not answered
20. / Thyroid / Parathyroid disease / Calcium deficiency

not answered
21. Hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome)

not answered
22. / High cholesterol / Taking statin drugs

not answered

23.	Diabetes / Type I / Type II	not answered
	HbA1c / Average blood sugar Less than 7% / less than 140 mg/dL ~ 7.8 mmol/L / 7-9% / between 140 to 200 mg/dL ~ 7.8 to 11.1 mmol/L / More than 9% / more than 220 mg/dL ~ 12.2 mmol/L	
24.	Stomach ulcer / Duodenal ulcer	not answered
25.	Digestive or eating disorders / Celiac disease / Gastric reflux / Bulimia / Anorexia / Irritable bowel syndrome / Inflammatory bowel disease / Crohn's / Other digestive disorders	not answered
26.	Osteoporosis / Osteopenia (i.e. taking bisphosphonates) / Ever taken anti-resorptive medications	not answered
27.	Arthritis / Gout	not answered
28.	Autoimmune disease: / Rheumatoid arthritis / Lupus / Scleroderma / Other	not answered
29.	Glaucoma	not answered
30.	Contact lenses	not answered
31.	Head injuries / Neck injuries	not answered
32.	Epilepsy, convulsions (seizures) / Controlled / Frequent	not answered
33.	Neurologic disorders: / Alzheimer's disease / Dementia / Prion disease	not answered
34.	Viral infections / Cold sore / Bacterial infections / Lyme disease	not answered
35.	Lumps in the mouth / Swelling in the mouth	not answered
36.	Hives / Skin rash / Hay fever / Other skin disease	not answered
37.	STI / STD / HPV	not answered
38.	Hepatitis: / Type A / Type B / Type C	not answered
39.	HIV / AIDS	not answered
40.	Radiation therapy	not answered
41.	Chemotherapy / Immunosuppressive medication	not answered
42.	Difficulties with stress management	not answered
43.	Psychiatric treatment / Antidepressant medication / Mood stabilizing medications	not answered
44.	Concentration problems / ADD/ADHD diagnosis	not answered
45.	Occasional alcohol consumption (1 to 4 drinks per week) / Daily alcohol consumption / Recreational drug use	not answered
Are you?		
46.	Presently being treated for any other illness	not answered
47.	Taking medication for weight management	not answered

48.	Taking any of the following / Supplements / Probiotics / Vitamins	not answered
49.	Often exhausted or fatigued	not answered
50.	/ Experiencing frequent headaches / Experiencing chronic pain	not answered
51.	/ A smoker / Used to smoke / A smokeless tobacco user / Vaping / An e-cigarette user / A cannabis user	not answered
52.	FEMALE - taking birth control pills	not answered
53.	Currently pregnant or breastfeeding / 1st Trimester / 2nd Trimester / 3rd Trimester	not answered
Other Questions		
54.		not answered
Medication List		
Supplements & Vitamins		

