GARY L DENNINGTON DDS PC
Fellow of the American Academy of Craniofacial Pain
Diplomate of the American Board of Craniofacial Pain

Today's Date :_____

Patient's Name_____SSN_____Birthdate_____

Name of parent (if child) or responsible party_____SSN_____Birthdate_____

Address _____Home Phone _____Cell Phone_____

City, State, Zip_____ Fax Number_____

E-Mail Address_____

Place of employment_____ Bus. Phone_____

Friend or nearest relative not living with you _____Phone_____

Spouses name _____Date of Birth _____SSN_____

Spouse's employment _____Bus Phone_____

Dental Insurance Company _____Effective Date_____

Whom may we thank for this referral? _____

DENTAL HISTORY

What prompted you to seek dental care at this time? _____

When was your last dental visit? _____Are you having any discomfort now? _____

Are you wearing removable dentures or partials? _____If so, when was the initial placement? _____

Are you concerned about the appearance of your teeth? _____

HEALTH HISTORY

Women Only: Are you pregnant? ___Yes ___No

Has there been any change in your general health within the past year? _____

Have you had any serious illness or operation? _____

If so, explain_____

Are you allergic or have had reactions to any of the following?

Local anesthetics ___Yes ___No
Penicillin…….___ Yes ___No
Other……...___ Yes ___No
_____

Aspirin. ___ Yes ___ No
Codeine ___ Yes ___ No
Latex..... ___ Yes ___ No

Are you taking any medicines for Osteoporosis, Osteoarthritis, or Osteopenia or any other bisphosphonate drugs such as Boniva, Fosomax, or Actonel? _____If yes has it been less than 3 years or more than 3 years?_____

Have you ever had Chemotherapy or Radiation treatments? _____ If yes, when? _____

Please list the names of any medications you are taking:

Acid Reflux _____
Blood thinners _____
High blood pressure_____
Steroids_____
Tranquilizer_____
Aspirin_____
Insulin or other diabetic med_____
Nitroglycerin_____
Oral Contraceptive_____
Hormonal therapy_____

Please list other medications and what they are for:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you have or have you had any of the following? **Mark an X on the ones that apply:**

Artificial heart valves …… _____
Congenital heart lesions……. _____
High blood pressure……_____
Heart attack, stroke…… _____
Coronary occlusion, arteriosclerosis…….. _____
Stints…….. _____
Bypass ……_____
Pacemaker ……..._____
Defibrillator ……_____
Asthma……... _____
Lupus or other immunosuppressive……..._____
Arthritis……. _____
Diabetes……. _____
Does your mouth become frequently dry……. _____
Are you thirsty much of the time…….. _____
Do you urinate more than 8 times a day……... _____
Gum Disease……. _____
Gum Surgery……. _____

Artificial limbs……. _____
Joint Replacement…… _____
Organ Transplant……. _____
Cancer…….. _____
Glaucoma……. _____
Stomach ulcers/hiatal hernia…… _____
Tuberculosis……. _____
Seizures…… _____
AIDS or HIV…… _____
Smoke/Tobacco…… _____
Hepatitis……... _____
Eating Disorder…… _____
Drug abuse…… _____
Do you snore? ……. _____
Do you wear a C-Pap? …… _____
Have you had a sleep study? …….. _____
TMJ……. _____

Is there any disease, condition or problem not listed that we should be aware of? _____

If yes, explain. _____

PAYMENT POLICY: Total payment of fees is required at the time of dental treatment. We will assist you in filing insurance claims. We ask that your portion, i.e. the co-payment and deductible, be paid as services rendered due to lab fees and other expenses.

I certify that I have read and understand the above payment policy. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____
SIGNATURE OF PATIENT or GUARDIAN