

**Capitola Dental Group
Robert Schellentrager, D.M.D.**



Patient Medical/Dental History Form

Name: _____

Date of Birth: _____

Medical History

Have you ever had any of the following? Please check all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis, A, B, C | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Psychological Disorders |
| <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Mitral Valve Prolapse |

Are you currently pregnant? ___ Yes ___ No If yes, how many months? _____

| | |
|--|--|
| Have you had any serious illnesses in the past two years? If yes, please provide more information. | |
| Please list any current medications: | |
| Are you taking or have you ever taken any Bisphosphonate drugs? | |
| Do you have any allergies to Penicillin or other drugs? Please list: | |
| Do you suffer from sleep apnea? | |
| Do you snore? | |
| Have you ever had a sleep study? | |
| Is your blood pressure normal, high or low? | |
| Do you smoke? If so, how many Per day? | |
| Do you have any other health conditions that we should be aware of or that may affect your dental/oral health? | |

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Dental History Cont'd

Are you concerned about or experiencing any of the following dental problems? (Please check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Existing crowns, bridges, or dentures | <input type="checkbox"/> Ability to eat | <input type="checkbox"/> Gaps between teeth |
| <input type="checkbox"/> Hygiene (brushing, cleaning, flossing) | <input type="checkbox"/> Your Smile | <input type="checkbox"/> Discoloration of teeth |
| <input type="checkbox"/> Previous dental treatment | <input type="checkbox"/> Missing teeth | <input type="checkbox"/> Silver fillings |
| <input type="checkbox"/> Crooked teeth | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Painful/Irritated gums |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Sensitive Teeth |

What is the main purpose of your visit here today? _____

How long since your last dental visit? _____ Last cleaning? _____

Does dental treatment make you nervous? _____

Have you ever had or do you require the following for dental treatment?

- Gas (Nitrous oxide) Intravenous sedation General Anesthesia

CONSENT FOR SERVICES

- I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics as indicated, and I assume financial responsibility for the fees associated with those procedures.
- I understand that the practice requires a minimum of 24 business hours notice for all cancelled or rescheduled appointments. A cancellation or rescheduling fee of \$50 is charged for all appointments where 24 business hours notice is not given. I have been made aware of the business hours of the office.
- I hereby consent to the use of any study models, x-rays, computer images and photographs at various dental seminars, lectures, and publications that the dentist may author.
- I am aware that payment for services is required on the day of treatment.

Patient/Legal Guardian Signature _____ **Date** _____