2525 South Wadsworth Blvd. #23
Lakewood CO 80227

(303)985-0909
happytooth@toothmansion.com

Mark Granger, D.D.S.

www.toothmansion.com

Medical & Dental History Form

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Why are you here today?

- ☐ Toothache
- ☐ Pain or swelling
- ☐ Cavities
- ☐ Checkup and cleaning
- ☐ Dentures
- ☐ Wisdom Teeth
- ☐ Implants
- ☐ Cosemetics
- ☐ Consultation

If you have dental anxiety how would you rate this? "0" being no anxiety to "10" being very fearful.

Would you consider yourself to be in fairly good health?

○ Yes ○ No

Within the past year, have there been any changes in your general health?

○ Yes ○ No

Your Primary Care Physician's name, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

- ☐ Have you ever had complications following medical or dental treatment?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized or had an emergency room visit within the last 5 years?
- ☐ Do you require the use of corrective lenses (contacts or glasses)) or hearing aids?
- ☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

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If any of the previous questions are marked, please explain:

Please indicate if you have experienced any of the following:

- [ ] Acid Reflux
- [ ] AIDS/HIV
- [ ] Allergies
- [ ] Amoxicillin Allergy
- [ ] Anemia
- [ ] Angina/Chest Pain
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Cancer
- [ ] CHF/Heart Failure
- [ ] Codeine Allergy
- [ ] Diabetes
- [ ] Dizziness
- [ ] Eating Disorder
- [ ] Emphysema
- [ ] Endocarditis
- [ ] Epilepsy/Seizures
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Hay Fever
- [ ] Head Injuries
- [ ] Hearing Aid
- [ ] Heart Attack
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart Surgery
- [ ] Hemophilia
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] Irregular Heart Beat
- [ ] Kidney Disease
- [ ] Latex Allergy
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] MetabisulfiteAllergy
- [ ] Migraines/Headaches
- [ ] Multiple Sclerosis
- [ ] Nervous Disorders
- [ ] Oral Contraceptives
- [ ] Pacemaker
- [ ] Pain in Jaw Joints
- [ ] Penicillin Allergy
- [ ] Premed Amoxicillin
- [ ] Psychiatric Therapy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Shortness of Breath
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Sulfa Drug Allergy
- [ ] Swollen Ankles
- [ ] Thyroid Condition
- [ ] Tobacco Use
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Tylenol Allergy
- [ ] Ulcers/Colitis
- [ ] Venereal Disease/STD
- [ ] Yellow Jaundice

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Please list prescription and nonprescription medications. The dosages and why you are taking them? If you have a written list we can scan this into your chart.

WOMEN ONLY:

- [ ] Are you pregnant now?
- [ ] Are you trying to get pregnant or possibly be pregnant now?
- [ ] Do you practice birth control?
- [ ] Are you nursing?

If you are pregnant what is your due date?

Do you have any other health issues or allergies?

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When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please check any of the following that you use in your personal homecare routine.

☐ Electric toothbrush ☐ Sonacare toothbrush ☐ Rota-dent
☐ Toothpicks or Rotapoints ☐ Prescription fluoride gel ☐ Peridex (Chlorohexidne)
☐ Periostat ☐ Waterpik

When was the last time your teeth were cleaned?

Please mark any of the following to indicate Yes in response to the question:

☐ Do you have a current full mouth series of radiographs?
☐ Do your gums bleed when you brush or floss?
☐ Have you had periodontal treatment or gum surgery?
☐ Are any of your teeth currently causing you pain?
☐ Do your teeth experience sensitivity to cold or hot temperatures?
☐ Do ever experience sharp electrical pain when biting?
☐ Do you grind or clench your teeth (either consciously or during sleep)?

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- [ ] Do you wear a TMJ splint or mouth guard?
- [ ] Are any of your teeth loose, or are you concerned about any teeth loosening?
- [ ] Does food pack in between any of your teeth?
- [ ] Do you currently have any dental implants, dentures, or partials?
- [ ] Have you had your wisdom teeth or 3rd molars removed?
- [ ] Have you had orthodontia or braces to straighten your teeth?
- [ ] Are you unhappy with the appearance of your teeth?
- [ ] Have you ever bleached or whitened your teeth?

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

- [ ] Is there anything you would like to discuss with Dr. Granger in private?

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Bisphosphonates - associated osteonecrosis of the jaw (BON)

Bisphosphonates are drugs widely used in the management to reduce bone pain, hypercalcemia and skeletal complications in patients with multiple myeloma, breast, lung and other cancers and Pagets disease of bone. These drugs are also used for the treatment of osteoporosis. Please answer the following questions:

Are you being treated for cancer of any kind?

◯ Yes ◯ No

Are you being treated of osteoporosis?

◯ Yes ◯ No

Have you or are you receiving any of the following bisphosphonates?

◯ Actonel (Risedronate) ◯ Boniva (Ibandronate) ◯ Fosamax(Alendronate)

◯ Aredia (Pamidronate) ◯ Zometa (Zoledronate) ◯ Other Bisphosphonate

Are you receiving any of these bisphosphonates in your veins, or intravenously?

◯ Yes ◯ No

Who is your physician who monitors these bisphosphonate drugs for you?

May I have your permission to speak directly with your physician regarding your treatment?

◯ Yes ◯ No

General Consent

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.
Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless there are some common risks associated with virtually any dental procedure, including:

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1. Drug or chemical reaction. Dental materials and medications may trigger allergic or sensitivity reactions. 2. Long-term numbness (paresthesia). Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness. 3. Muscle or Joint tenderness. Holding one'e mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder. 4. Sensitivity in teeth or gums, infection, or bleeding 5. Swallowing or inhaling small objects.
While we follow procedural guidelines which most often lead to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____