Mark Granger, D.D.S.

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Medical & Dental History Form

Patient Name:				
Last		First	MI	Preferred Name
	t us know about your medic our overall health and well-b		ory so we may serv	ve you more effectively and in
Why are you here today?				
Toothache	Pain or swelling	Cavities		
Checkup and cleaning	Dentures	Wisdom	Teeth	
Implants	Cosemetics	Consulta	ation	
If you have dental anxiety h	ow would you rate this? "0"	being no anxiety to	o "10" being very fe	earful.
Would you consider yoursel	If to be in fairly good health?			
Yes No				
Within the past year, have t	here been any changes in ye	our general health	?	
○ Yes ○ No				
Your Primary Care Physicia	n's name, address, & phone	e number:		
Please mark any of the folio	owing to indicate Yes in resp	onse to the questi	on:	
Have you ever had comp	olications following medical of	or dental treatment	t?	
Are you currently under t	he care of a physician due t	to a specific condit	ion?	
Have you been hospitaliz	zed or had an emergency ro	om 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	e experienced any of the follo	owing:			
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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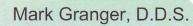
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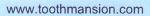
Please list prescription and nonprescription medications. The dosages and why you are taking them? If you have a written list we can scan this into your chart.
WOMEN ONLY:
Are you pregnant now?
Are you trying to get pregnant or possibly be pregnant now?
Do you practice birth control?
Are you nursing?
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)?				





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 Bis	phosphonate			
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 detail 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:

