Robyn G. Call DMD

Jeffrey E. Fellner DDS

Ronald K. Shelley DMD MAGD

ARROWHEAD LAKES DENTISTRY PC

Welcome

Thank you for giving us the opportunity to serve your dental needs. Please fill out this form completely.

Name: _____
Last First MI

❑ Male
I prefer to be called: _____ ❑ Female

Birthdate ____/____/____ SS#: _____

Email: _____

Home Address: _____
Street Apt No.

_____
City State Zip

❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Home # (____) _____ Cell # (____) _____

Work # (____) _____ Driver Lic # _____

Full Time Student? NO Yes -- School Attending: _____

Employer: _____

Emplorer's Address _____
Street Suite

_____
City State Zip

How Long There? _____ Occupation _____

Where & when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Spouse's Name: _____

Employer: _____

Work # (____) _____ SS#: _____

Birthdate: ____/____/____ Driver Lic # _____

Person Responsible for Account: ❑Patient ❑Spouse

❑ Other: _____

Work # (____) _____ Home # (____) _____

Billing Address _____
Street Apt #

_____
City State Zip

Relation: _____ SS#: _____

Birthdate: ____/____/____ Driver Lic #: _____

Employer: _____

Today's Date ____/____/____

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local or Policy#) _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured ID# _____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local or Policy#) _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured ID# _____

Insured's Employer: _____

Employer's Address: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Realtion: _____

Work # (____) _____ Home # (____) _____

Medical History

Physician's Name: _____

Work # (____) _____ Date of Last Visit _____

Are you currently under the care of a Physician? ❑ Yes ❑ No

Please Explain: _____

_____

Have you ever had any of the following diseases or medical problems? (Please circle the option that applies)

Yes	No	Abnormal Bleeding	Yes	No	HIV+ or AIDS
Yes	No	Alcohol abuse	Yes	No	Heart Attack
Yes	No	Allergies	Yes	No	Heart Disease
Yes	No	Anemia	Yes	No	Hepatitis
YES	No	Angina Pectoris	Yes	No	High Blood Pressure
Yes	No	Arthritis	Yes	No	Injury to Head or Face
Yes	No	Artificial Heart	Yes	No	Kidney Problems
Yes	No	Artificial Joints	Yes	No	Liver Disease
Yes	No	Asthma	Yes	No	Low Blood Pressure
Yes	No	Blood Disease	Yes	No	Mitral Valve Prolapse
Yes	No	Breathing Problems	Yes	No	Pacemaker
Yes	No	Cancer-Chemotherapy	Yes	No	Psychiatric Problems
Yes	No	Circulatory Problems	Yes	No	Radiation Therapy
Yes	No	Colitis	Yes	No	Rheumatic Fever
Yes	No	Congenital Heart Disease	Yes	No	Seizures
Yes	No	Cosmetic Surgery	Yes	No	Sexually Trans. Disease
Yes	No	Diabetes	Yes	No	Sinus Problems
Yes	No	Drug Abuse	Yes	No	Sleep Apnea
Yes	No	Emphysema	Yes	No	Stroke
Yes	No	Epilepsy	Yes	No	Thyroid Problems
Yes	No	Fainting spells	Yes	No	Tuberculosis (TB)
Yes	No	Gastroesophogeal Reflux	Yes	No	Ulcers
Yes	No	Glaucoma			

Please list any serious medical conditions that you have ever had or explain any "yes" answers from the list above: _____

_____

_____

Are you allergic or had an adverse reaction to any of the following?

Yes	No	Aspirin	Yes	No	Jewelry / Metals
Yes	No	codeine	Yes	No	Latex
Yes	No	Dental Anesthetics	Yes	No	Penicillin
Yes	No	Erythromycin	Yes	No	Tetracycline

Please list any other drugs or materials that you are allergic or have had an adverse reaction to: _____

_____

Are you taking any prescription drug, over-the-counter medication, or supplement?

Please list each one: _____

_____

__ _____

Yes No Females: Are you pregnant? If so, how many weeks: _____

Yes No Females: Are you nursing?

Your current physical health is (please circle): Good Fair Poor

Yes No Has a physician recommended that you need to take Antibiotics before dental treatment?

Yes No do you smoke or use tobacco in any other form?

Yes No Have you ever taken Fosamax or any other bisphosphonate?

Yes No Do you use CPAP or have ever tried to use CPAP?

Yes No Do you snore?

Yes No Do you have High Blood Pressure?

Yes No Has anyone reported that you choke or gasp for air While sleeping?

What is your neck size (in inches)? _____

Yes No do you awake refreshed?

Yes No Are you excessively tired during the day?

Yes No Do you get Headaches? If so, please answer the next 6 questions

How often? _____

Has there been a change in your headache pattern? _____

_____

Does anything trigger your headaches? _____

To what degree would you say your headaches effect your life? ___

_____

On a scale of one (least) to ten (worst), what is the range of your headaches? _____

Have you been treated or evaluated for your headaches? _____

Dental History

How would you rate your current dental Health? Good Fair Poor

Date of your last dental visit: _____

Why have you come to the dentist Today? _____

_____

Yes No Are you currently in pain?

Yes No do your gums ever bleed?

Yes No Are your teeth sensitive to hot, cold, or chewing?

Yes No Have any complication with any previous dental work?

Yes No Have you ever had any head, neck, or jaw injury?

Yes No Ever had orthodontic treatment (braces)?

Yes No Ever had any oral surgery?

Yes no Ever had any periodontal (gum) treatment?

Yes No Ever wear any full or partial denture?

Yes No Ever had any dental implants?

Yes No Are you aware if you clench or grind your teeth?

Yes No Are you presently aware of joint sounds?

Yes No Did you ever have joint sounds?

Yes No do you ever have pain or soreness in front of your ears?

Yes No Do you have ear pain?

Yes No do you wake up with your jaws sore or tired?

Yes No Do you ever have difficulty opening widely?

Yes No Do you avoid eating certain foods because of discomfort?

Yes No Have you ever worn a biteGuard, splint, or nightguard?

Yes No Would you like to change anything about your smile?

If so, please explain: _____

How many times a day do you brush your teeth? _____

How many times a week do you Floss? _____

Is there anything else you want us to know about your medical and dental Health? _____

_____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

signature Date