Denture Masters™ & Implant Center

Name:_____ **Birth date**:___/___/____
Address:_____ City: _____ State:_____
Zip Code:_____ Phone #:_____ E-mail: _____
By providing your e-mail, you are agreeing to receive information through an unencrypted e-mail system.
Employer:_____ Phone #: _____ Address:_____
Insurance Co: _____ Policy Holder: _____ Policy Holder's D.O.B: _____
Policy #:_____ Patient's SS# (For insurance):_____ Policy Holder's SS#:_____
Why did you make this appointment?:_____
How did you hear about us?:_____
Current Medications you are taking: _____
_____
Allergies to medications?: _____
Are you under the care of a physician? **Yes / No** If yes, for what? _____
Physicians Name?: _____ Phone #: _____
Have you had any complications following dental treatment?: _____
Have you been admitted into the hospital during the past two years?: _____
Do you currently wear full or partial dentures?: _____

Please check any condition that applies to you, or has applied to you in the past:

- ○ Aids / HIV
- ○ Anemia
- ○ Artificial Joints
- ○ Asthma
- ○ Blood disease
- ○ Cancer
- ○ Diabetes
- ○ Dizziness
- ○ Epilepsy
- ○ Excessive bleeding
- ○ Fainting
- ○ Glaucoma
- ○ Metal Plates/Pins
- ○ Hay Fever
- ○ Head injuries
- ○ Heart Disease
- ○ Heart Murmur
- ○ Hepatitis
- ○ High Blood Pressure
- ○ Kidney Disease
- ○ Liver Disease
- ○ Mental Disorders
- ○ Nervous Disorders
- ○ Pacemaker
- ○ Heart Valve Problems
- ○ Pregnant: Current? Yes / NO
- ○ Radiation Treatment
- ○ Respiratory System
- ○ Rheumatic Fever
- ○ Sinus issues
- ○ Sleep Apnea
- ○ Stomach issues
- ○ Stroke
- ○ Tuberculosis
- ○ Tumors
- ○ Venereal Disease
- ○ Breast or other implants?

STAFF NOTES:

Pre-Med: YES NO
ALLERGIES:_____
_____
_____

Blood thinner: YES NO

Health Hx Updates:

Any other conditions not listed above? _____
Are you currently taking **Aspirin**? **YES NO**
Are you taking any **blood thinner** other than Aspirin? **YES NO**
Do you have any medical purpose for taking an antibiotic **PRIOR** to a dental procedure? **YES NO**
Do you use any tobacco or marijuana products? **YES NO** If so, what kind and how frequent? _____

Consent for Services:

I authorize the doctor to perform recommended treatment if I so choose. I agree to the use of anesthetics and other medications as necessary. I fully understand that using anesthetic agents has risks involved and I may ask for a complete explanation of such. I agree to a panoramic and/or 3-D x-ray to be taken today, at no charge. If I choose to move forward with treatment here at Denture Masters & Implant Center, or if I request to take the x-ray with me, or have it be sent to a third party, it is at that time that I will pay the x-ray fee of $285 for 3-dementional, and $133 for panoramic.

Signature of Patient:_____**Date**:_____