7502 E Pinnacle Peak Rd, B-119, Scottsdale, AZ 85255

O | **(480) 306-8510** F | **(480) 306-8520**

W | www.scottsdaleimplantdentistry.com

SCOTTSDALE CENTER FOR IMPLANT DENTISTRY

PATIENT INFORMATION FORM

WELCOME

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health.

- PLEASE FILL OUT THIS FORM COMPLETELY. -

THE BETTER WE COMMUNICATE,
THE BETTER WE CAN CARE FOR YOU.

1 ABOUT YOU

Name _____

Preferred Name _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed

Birthdate / / Age ____ **SS#** _____

Address _____

City _____ State ____ Zip ____

Email _____

Home# _____ Work# _____

Mobile# _____ Fax# _____

Other family members seen by us _____

Employer _____

2 ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____

Home# _____ Work# _____

Mobile# _____ Birthdate / /

Email _____

Billing Address _____

City _____ State ____ Zip ____

3 SPOUSE INFO

Name _____

Home# _____ Work# _____

Mobile# _____ Birthdate / /

Email _____

4 INSURANCE

Provider Name _____

Provider Address _____

City _____ State ____ Zip ____

Group# _____

Insured's Name _____ Relation ____

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

Insured's Employer _____ Insured's Ph# ____

WHO REFERRED YOU TO OUR OFFICE?

Name _____

Ph# _____

City _____ State ____ Zip ____

Notes _____

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5 Medical History

Your current physical condition ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

Are you taking any herbal supplement drugs? ☐ Yes ☐ No

Please list _____

_____

Have you ever taken Phen-Fen? ☐ Yes ☐ No

(Also known as Redux or Pondimin) If yes, when_____

FOR WOMEN ONLY

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Yes	No	Abnormal Bleeding	Yes	No	Herpes/Fever Blisters
Yes	No	Alcohol/Drug Abuse	Yes	No	High Blood Pressure
Yes	No	Anemia	Yes	No	HIV+/AIDS
Yes	No	Arthritis	Yes	No	Hospitalized (Any Reason)
Yes	No	Artificial Bones, Joints or Valves	Yes	No	Kidney Problems
Yes	No	Asthma	Yes	No	Liver Disease
Yes	No	Blood Transfusion	Yes	No	Low Blood Pressure
Yes	No	Cancer/Chemotherapy	Yes	No	Lupus
Yes	No	Colitis	Yes	No	Mitral Valve Prolapse
Yes	No	Congenital Heart Defect	Yes	No	Pacemaker
Yes	No	Diabetes	Yes	No	Psychiatric Problems
Yes	No	Difficulty Breathing	Yes	No	Radiation Treatment
Yes	No	Emphysema	Yes	No	Rheumatic/Scarlet Fever
Yes	No	Epilepsy	Yes	No	Seizures
Yes	No	Fainting Spells	Yes	No	Shingles
Yes	No	Frequent Headaches	Yes	No	Sickle Cell Disease
Yes	No	Glaucoma	Yes	No	Sinus Problems
Yes	No	Hay Fever	Yes	No	Stroke
Yes	No	Heart Attack	Yes	No	Thyroid Problems
Yes	No	Heart Murmur	Yes	No	Tuberculosis (TB)
Yes	No	Heart Surgery	Yes	No	Ulcers
Yes	No	Hemophilia	Yes	No	Venereal Disease
Yes	No	Hepatitis			

Please list any medical conditions/treatment or surgeries I should know about? _____

_____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

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

Please list any allergies not listed here:_____

_____

_____

_____

_____

6 Medical Info

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name _____

Phone# _____ Last Visit Date / /

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain_____

Head and Neck Surgeon_____

Phone #_____

Notes_____

Oncologiest_____

Phone #_____

Notes_____

Radiation Oncology Clinic_____

Phone #_____

Notes_____

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name_____ Relation_____

Home#_____ Work#_____

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7 Dental History

Why have you come to the dentist today?_____

_____

Has your doctor told you that you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is? ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you use floss? _____

How many times a day do you brush?_____

Type of toothbrush bristles? ☐ Hard ☐ Medium ☐ Soft

Have you had dental implants placed? ☐ Yes ☐ No

Surgeon's Name _____

Phone #_____

Restorative Dentist's Name _____

Phone # _____

8 Medications

Please list all prescription medications you are taking:

_____

_____

_____

_____

_____

Are you currently or have you taken any of the following for thetreatment of osteopenia or osteoporoisis? ☐ Yes ☐ No

☐ Alendronate (Fosamax)

☐ Risedronate (Actonel)

☐ Ibandronate (Boniva)

Are you currently taking or have you taken any of the following for the treatment of bone metatasis? ☐ Yes ☐ No

☐ Pamidronate (Aredia

☐ Zoledronate (Zometa)

Are you currently or have you taken any of the following for the treatment of osteopenia or osteoporoisis? ☐ Yes ☐ No

☐ Etidronate (Didronel)

☐ Tiludronate (Skelid)

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PATIENT INFORMATION FORM

9 DISCLAIMER

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

Signature_____

Date _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

10 PRIVACY PRACTICES

Michael L. Bleeker, DMD, FACP

ACKNOWLEDGEMENT OF NOTICE

OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgement****

I,_____, understand that Dr. Bleeker's Office Abides by the HIPAA Law and will protect the privacy of your personal information

Please Print Name_____

Signature _____

Date _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement for the receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign.

____ Communication barriers prohibited us from obtaining acknowledgement.

____ An emergency situation prevented us from obtaining acknowledgment.

____ Other (Please Specify)

THANK YOU!

We appreciate you for filling out this form completely.
It will allow us to serve you more effectively

If you have a question at any time, please call us. *We are happy to help.*

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WELCOME PAGE - Q&A

We warmly welcome you.

To better serve you, please take just a couple minutes to answer the following questions. Thanks!

Please check any of the following problems that apply to you:

- ☐ Sensitivity (hot, cold or sweet)
  If so, which teeth
- ☐ Headaches, earaches, neck pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen, or irritated gums
- ☐ Loose, tipped, or shifting teeth
- ☐ Bad breath

Do you have or have you had any of the following?

- ☐ Dentures
- ☐ Partial Dentures
- ☐ Periodontal (gum) treatments

Please share the following approximate dates:

Your last cleaning_____

Your last oral cancer screening_____

Your last complete x-rays_____

Who was your previous dentist?

Name:_____

City:_____State:_____

Phone:_____

What is the most important things to you about your smile and dental health?_____

_____

_____

Do you smoke or use chewing tobacco

☐ Yes ☐ No

If yes, how much? And, for how long?

If you could change your smile, would you:

(Please check all that apply)

- ☐ Make your teeth whiter
- ☐ Make your teeth straighter
- ☐ Close spaces between teeth
- ☐ Replace black metal fillings with tooth-colored restorations
- ☐ Repair chipped teeth
- ☐ Replace missing teeth with dental implants
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

On a scale of 1 to 5, with 5 being the highest rating:

(Please circle the numbers that best applies)

How important is your dental health to you?

1 2 3 4 5

How would you rate your current dental health?

1 2 3 4 5

Where do you want your dental health care to be?

1 2 3 4 5

What is the most important thing to you about your dental visit today?_____

_____

_____