Lake Superior Dental associates

Patient Name:_____ Doctor Signature:_____

Reason for today's visit:_____ Patient Date of Birth:_____ Reviewed by and Date:_____

(Clinical Staff use only)

General Health

(Please check box if applies to you now or in the past)

- ☐ Abnormal Bleeding
- ☐ Acid Reflux
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bisphosphonate Therapy
- ☐ Cancer - Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Defect
- ☐ Cortisone Treatments
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ GERD
- ☐ HIV/AIDS
- ☐ Heart Murmur
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pace Maker
- ☐ Pregnant (currently)
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stroke

Other

- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor Head or Neck
- ☐ Ulcers
- ☐ Other Problems (list)

_____

(Office Use Only)

Patient Blood Pressure:_____

Gender:_____ Are you pregnant?_____ If yes, # of weeks_____

Are you taking birth control pills?_____ Are you nursing?_____

Do you smoke, use tobacco products, or e-cigarettes?_____

Name of your Primary Physician:_____His/Her phone number:_____

Are you under the care of a Specialist Physician, if so who:_____His/Her Phone number:_____

Allergies: Please check box if *any* of these allergies applies to you:

- ☐ Penicillin or other antibiotics
- ☐ Aspirin
- ☐ Codeine or other narcotics
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Sulfa Drugs
- ☐ Reactions to metals
- ☐ Other?

_____

Please list all medications, vitamin supplements, and herbal remedies currently taking: (or provide list)

_____

_____

_____

_____

_____

Name of your Pharmacy:_____

By signing below I certify that the above is complete and accurate. I hereby authorize the doctors and dental professionals to perform dental exams, take x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctors at LSDA to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize the use of anesthetics and understand that use of anesthetics embodies a certain risk.

Patient Signature:_____Date:_____

(please turn over for page 2.....)

Patient Name:_____DOB:_____
Today's Date:_____

Is there a disease, condition, or problem not covered on page one that you think this office should know about?

Dental History

Date of Last visit:_____
Date of Last Dental X-rays:_____
Do you have bleeding gums? _____
Do you use tobacco? _____
Do you have a dry mouth often? _____
Does food collect between your teeth? _____
Do you grind or clench your teeth? _____
Do you have loose teeth or fillings? _____
Do you have jaw joint pain? _____ _____

Would you like your teeth to be straighter? _____
Would you like your teeth to be whiter?_____
Have you noticed any wear or chipping of your teeth? _____
If there is anything you could change about your teeth what would it be?_____

Sleep Health

Do you snore? _____
Do you wake-up not feeling refreshed? _____
Do you wake-up in the morning with headaches? _____
Is it hard to stay awake during the day? _____
Have you been told that you stop breathing while you sleep? _____