

Dr. Jepsen & Associates
A Professional Corporation

I. GENERAL INFORMATION

Date _____
Patient Name: _____
FIRST _____ MIDDLE _____ LAST _____
Social Security No. _____ Single _____ Married _____ Widowed _____ Divorced _____ Male _____ Female _____
Address _____ City _____ Zip Code _____
Home telephone _____ Business telephone _____ Cell telephone _____
Email Address _____
Employer _____ Occupation _____
Age _____ Height _____ Weight _____ Date of Birth _____
Spouse's name _____ Spouse's employer _____ Phone _____
Emergency contact _____ Relationship _____ Phone _____
Who referred you to this office _____

II. DENTAL INFORMATION

Purpose of today's visit _____
Number of cleanings in the last three years _____
Date of your last dental visit _____ What was done _____
Name of former dentist _____
How do you feel about the appearance of your teeth _____
What makes you nervous about dental treatment, if anything _____

Removable appliances

Do you wear removable dental appliances?Y___ N___ ?___
Would you be disturbed to lose all of your teeth?..Y___ N___ ?___
Did either of your parents lose all of their teeth?...Y___ N___ ?___

Periodontal conditions

Do your gums bleed when you brush?Y___ N___ ?___
Are spaces developing between your teeth?.....Y___ N___ ?___
Have you had any deep cleanings of your gums? ..Y___ N___ ?___
has anyone talked to you about gum disease?.....Y___ N___ ?___
Have you had "gum boils" or gum swellings?Y___ N___ ?___

TMJ

Do you have any discomfort in your jaw joints? ...Y___ N___ ?___
Do you experience any clicking or popping?Y___ N___ ?___
Do you experience tiredness in you jaw?Y___ N___ ?___
Are you aware that you clench or grind your teeth?.Y___ N___ ?___
Do you have headaches?.....Y___ N___ ?___
Do you have a nightguard/splint?Y___ N___ ?___

IIIa. HEALTH INFORMATION

Has there been any changes in your general health in the past year Y___ N___ ?___
Are you now under the care of a physician Y___ N___ ?___
For what conditions _____
Date of your last physical examination _____
Physician name _____ Phone number _____
Have you had any serious illness, operation, or been hospitalized in the past 5 years Y___ N___ ?___
What was the illness or problem _____

How much alcohol did you drink in the last 24 hours, if any _____
Are you (or were you at one time) alcohol/drug dependent Y___ N___ ?___
Do you use tobacco (smoking, snuff, chew) Y___ N___ ?___
How interested are you in stopping _____

Are you taking or have you taken any diet drugs such as Pondimin (fenfluramine), Reduz or Phen fen Y___ N___ ?___

For Female Patients Only

Are you or could you be pregnant Y___ N___ Nursing Y___ N___ Taking birth control pills Y___ N___
I have been advised that certain antibiotic, aspirin products, antacids, and other medications commonly prescribed for dental conditions, may interfere with the reliability of oral contraceptives which may result in an unwanted pregnancy. I have been advised that, if I am on oral contraceptives and I am prescribed medications during my dental treatment, I should consult with my gynecologist or primary care physician as to what other precautions I should employ to prevent an unwanted pregnancy during any period of time that I am taking these medications. This includes all antibiotics that are placed in gingival pockets during gum disease treatment. Knowing these risks, I consent to prescribed antibiotics by Dr. Jepsen, Dr. Murphy, or Dr. Stevens.

patient signature

IIIb. MEDICAL HISTORY

Are you allergic to or have you had a reaction to:

Local anesthetics, Aspirin, Penicillin or other antibiotics, Sulfa drugs, Codeine or other narcotics, Latex, Iodine, Hay fever, seasonal allergies

Please specify type of reaction:

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacementY___ N___ ?___

Has a physician/dentist recommended that you take antibiotics prior to dental treatment.Y___ N___ ?___

What kind _____

Please indicate if any of the following diseases or conditions apply (past or present):

ArthritisY___ N___ ?___
Rheumatoid ArthritisY___ N___ ?___
EmphysemaY___ N___ ?___
AsthmaY___ N___ ?___
TuberculosisY___ N___ ?___
Blood transfusionY___ N___ ?___
StrokeY___ N___ ?___
Taking blood thinnerY___ N___ ?___
Cardiovascular (Heart) diseaseY___ N___ ?___
 AnginaY___ N___ ?___
 ArteriosclerosisY___ N___ ?___
 Artificial heart valveY___ N___ ?___
 Congenital heart defectsY___ N___ ?___
 Congestive heart failureY___ N___ ?___
 Coronary artery diseaseY___ N___ ?___
 Heart attackY___ N___ ?___
 High blood pressureY___ N___ ?___
 Low blood pressureY___ N___ ?___
 Mitral valve prolapseY___ N___ ?___
 Heart murmurY___ N___ ?___
 Rheumatic heart disease/rheumatic feverY___ N___ ?___
 PacemakerY___ N___ ?___
Chest pain upon exertionY___ N___ ?___
Do you carry nitroglycerinY___ N___ ?___

DiabetesY___ N___ ?___
 Type I insulin dependentY___ N___ ?___
 Type II adult onsetY___ N___ ?___
Relatives with diabetesY___ N___ ?___
 Often thirstyY___ N___ ?___
 Urinate frequentlyY___ N___ ?___
Multiple SclerosisY___ N___ ?___
Hepatitis, jaundice, or liver diseaseY___ N___ ?___
Eating DisorderY___ N___ ?___
Epilepsy/seizuresY___ N___ ?___
Gastrointestinal (GI) diseaseY___ N___ ?___
GI Reflux/persistent heartburnY___ N___ ?___
GlaucomaY___ N___ ?___
Hemophilia/AnemiaY___ N___ ?___
Abnormal bleedingY___ N___ ?___
Kidney disease/problemsY___ N___ ?___
Mental Health disorderY___ N___ ?___
 Specify _____
AIDS or HIV infectionY___ N___ ?___
CancerY___ N___ ?___
Chemotherapy or Radiation therapyY___ N___ ?___
Sexually transmitted diseaseY___ N___ ?___

Do you have any disease, condition, or problem not listed above that you think we should know about? _____

Are you taking any medication, including non-prescription? Y___ N___ ?___

Prescribed meds _____

Over the counter _____

Vitamins, natural, or herbal preparations _____

***At all subsequent appointments, please bring a list of all current medications

Are you taking or have you taken any Bisphosphonate drugs such as: Aredia (Pamidronate), Fosamax (Alendronate), Boniva (Ibandronate), Actonel (Risedronate), or Zometa (Zolendronate) Y___ N___ ?___

For All Patients

I give my consent to use local anesthetics, relaxants, nitrous oxide, or a combination for completing any necessary dental treatment. I also do ___ do not ___ grant permission to take photographs of my mouth to be used, without revealing my identity, for the furthering of dental knowledge and education.

patient signature

MEDICAL HISTORY NOTES/UPDATES:

