WELCOME TO UPLAND DENTAL GROUP AND IMPLANT CENTER

(This information in NECESSARY for our files and is CONFIDENTIAL)

PATIENT INFORMATION:

Last Name _____ First Name _____ Age _____ DOB _____ SSN _____ Male / Female

Home Address _____ City, State, Zip _____ Home Phone (___)_____ Cell Phone (___)_____ Email _____

Employer Name _____ Address _____ City, State, Zip _____ Work Phone (___)_____

PARENT/GUARDIAN INFORMATION:

Last Name _____ First Name _____ Age _____ DOB _____ SSN _____ Male / Female

Home Address _____ City, State, Zip _____ Home Phone (___)_____ Cell Phone (___)_____ Email _____

Employer Name _____ Address _____ City, State, Zip _____ Work Phone (___)_____

TELL US ABOUT YOURSELF!

Are you interested in (please circle all that apply): Teeth Whitening Implants A Nicer Smile Fresher Breath Healthy Gums

Rate your smile from 1-10 (10 being the best): 1 2 3 4 5 6 7 8 9 10

What would change about your smile? _____

How did you hear about us? _____

Persons living with you:

Last Name _____ First Name _____ Age _____ DOB _____ Relationship _____ Male / Female

Last Name _____ First Name _____ Age _____ DOB _____ Relationship _____ Male / Female

Last Name _____ First Name _____ Age _____ DOB _____ Relationship _____ Male / Female

Last Name _____ First Name _____ Age _____ DOB _____ Relationship _____ Male / Female

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

Name _____ City, State, Zip _____ Home Phone (___)_____ Cell Phone (___)_____ Email

FINANCIAL INFORMATION Payment Type: Cash Visa/Mastercard Carecredit Other:_____

Primary Insured:

Last Name _____ First Name _____ Age _____ DOB _____ SSN _____ Male / Female

Insurance Company _____ Eligibility Phone (___)_____ Subscriber ID _____

Secondary Insured:

Last Name _____ First Name _____ Age _____ DOB _____ SSN _____ Male / Female

Insurance Company _____ Eligibility Phone (___)_____ Subscriber ID _____

Health Questionnaire

Patient's Name: _____ Date: _____ DOB: _____

Sex: _____ Height: _____ Weight: _____ Occupation: _____ Marital Status: _____

Please check/circle the appropriate answer to the questions and fill in the blanks where indicated. Answer all questions and blanks completely. Answers to the following questions are for our records and will be considered confidential.

1. Are you in good health? ☐Yes ☐No
   A. Has there been any change in your general health? ☐Yes ☐No
2. My last physical examination was on: _____
3. Are you now under the care of a physician? ☐Yes ☐No
4. The name and address of my physician is: _____
5. Have you ever had a serious illness or operation? ☐Yes ☐No
6. Have you been hospitalized with any of the following within the last five years:
   A. Persistent cough or cough up blood? ☐Yes ☐No
   B. Low/High blood pressure (circle one) ☐Yes ☐No
   C. Venereal Disease ☐Yes ☐No
   D. AIDS or HIV+ ☐Yes ☐No
   E. Other _____
7. Have you had abnormal bleeding associated with previous extraction, surgery, or trauma? ☐Yes ☐No
   A. Do you bruise easily? ☐Yes ☐No
   B. Have you ever required a blood transfusion? ☐Yes ☐No

   (If yes, why) _____
8. Do you have any blood disorder such as anemia? ☐Yes ☐No
9. Have you had surgery or x-ray treatment for a tumor growth or other condition of your mouth or lips? ☐Yes ☐No
10. Are you taking any drug or medication? ☐Yes ☐No

    (If yes, what) _____
11. Are you taking any of the following:
    A. Antibiotics or sulfa drugs ☐Yes ☐No
    B. Anticoagulants (blood thinners) ☐Yes ☐No
    C. Medicine for high blood pressure ☐Yes ☐No
    D. Cortisone (steroids) ☐Yes ☐No
    F. Aspirin ☐Yes ☐No
    G. Insulin, Tolbutamide (Orinase) or similar drug ☐Yes ☐No
    H. Digitalis or drugs for heart trouble ☐Yes ☐No
    I. Nitroglycerin ☐Yes ☐No
    J. Fen-Phen (now or in the past) or related drug such as Ionimin, Adipex, Phentermine, Fastin, Podimimin (Fenfluramine), and Redux (dexfenfluramine) ☐Yes ☐No
    K. Oral Contraceptive ☐Yes ☐No

    (If yes, what are you using?) _____
    L. Chemotherapy Drugs ☐Yes ☐No
    M. Osteoporosis Drug (Fosamax, etc.)? ☐Yes ☐No
    N. Other _____ ☐Yes ☐No
12. Do you have a heart murmur/mitral valve prolapse? ☐Yes ☐No
13. Do you have any implants and/or Artificial Joints (i.e knee joint, elbow pins, ect.?) _____ ☐Yes ☐No
14. Do you drink alcoholic beverages? ☐Yes ☐No
15. Do you smoke? ☐Yes ☐No

    (If yes, how much?) _____
16. Do you have, or had, any of the following diseases or problems:
    A. Rheumatic fever or rheumatic heart disease ☐Yes ☐No
    B. Congenital heart lesions ☐Yes ☐No
    C. Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke)? ☐Yes ☐No
       1. Do you have pain in the chest upon exertion? ☐Yes ☐No
       2. Are you ever short of breath after mild exercise? ☐Yes ☐No
       3. Do you get short of breath when you lie down or do you require extra pillows when you sleep? ☐Yes ☐No
    D. Allergy ☐Yes ☐No
    E. Asthma or hay fever ☐Yes ☐No
    F. Hives or skin rash ☐Yes ☐No
    G. Fainting spells or seizures ☐Yes ☐No
    H. Diabetes ☐Yes ☐No
       1. Do you have to urinate (pass water) more than six times a day? ☐Yes ☐No
       2. Are you thirsty much of the time? ☐Yes ☐No
       3. Does your mouth frequently become dry? ☐Yes ☐No
    I. Hepatitis, jaundice, or liver disease ☐Yes ☐No
    J. Arthritis ☐Yes ☐No
    K. Inflammatory rheumatism (painful, swollen joints) ☐Yes ☐No
    L. Stomach ulcers ☐Yes ☐No
    M. Kidney trouble ☐Yes ☐No
    N. Tuberculosis ☐Yes ☐No
17. Are you allergic or have you reacted adversely to:
    A. Local anesthetic ☐Yes ☐No
    B. Penicillin or other antibiotics ☐Yes ☐No
    C. Barbiturates, sedatives, or sleeping pills ☐Yes ☐No
    D. Sulfa Drugs ☐Yes ☐No
    E. Aspirin ☐Yes ☐No
    F. Iodine ☐Yes ☐No
    G. Latex ☐Yes ☐No
    H. Other _____ ☐Yes ☐No
18. Have you had any serious trouble associated with previous dental treatment? ☐Yes ☐No

    (If yes, explain…) _____
19. Are you pregnant or could you be? ☐Yes ☐No

    (If yes, when are you due?) _____

I certify to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my dentist before my next visit.

_____
Patient/Guardian Signature Date

_____
Doctor Signature Date

Update: 2nd Year / 3Year

_____
Patient/Guardian Signature Date Dr.'s Initials

_____
Patient Guardian Signature Date Dr.'s Initials

Update: 4th Year / 5th Year

_____
Patient/Guardian Signature Date Dr.'s Initials

_____
Patient Guardian Signature Date Dr.'s Initials