DENTURE GALLERY
WACO

PATIENT HISTORY INFORMATION

Name: _____
(first name) (middle name) (last name)

Sex: ____ M ____ F **Date of Birth:** _____/_____/_____ **Social Security Number:** _____ – _____ – _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____ **E-Mail:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Emergency Contact Name: _____ **Emergency Contact Phone:** _____

Race: ____ African American ____ Asian American ____ Caucasian/White ____ Hispanic ____ Other

Name of Family Physician: _____ **City:** _____ **State:** _____

What is your reason for today's visit? _____

1) Have you received treatment in our office previously? ☐ YES ☐ NO If yes, when? _____

2) What specific communication led you to choose The Denture Gallery Today? (check one)

☐ Magazine ☐ Newspaper ☐ Radio ☐ Billboards/Sign ☐ Brochure/Mail ☐ Television

☐ Yellow Pages ☐ Friend/Relative ☐ Internet/Web Site ☐ Other Doctor ☐ Outside Agency

Do you have commercial dental insurance? ☐ Yes ☐ No

Name of insurance: _____

Speak with our front desk regarding options to utilize your insurance benefits.

Are you a current CareCredit cardholder? ☐ YES ☐ NO

Speak with our front desk regarding options to utilize cardholder benefits.

Are you currently wearing dentures? ☐ Yes ☐ No

Any previous tooth extractions? ☐ YES ☐ NO If yes, when? _____

Have you taken, are you taking, or are you scheduled to begin taking medications for osteoporosis?

☐ Oral Bisphosphonates: Alendronate (Fosamax, Fosamax Plus D) • Etidronate (Didronel) Ibandronate (Boniva) • Risedronate (Actonel) • Tiludronate (Skelid)

☐ Intravenous Bisphosphonates: Clodronate (Bonefos) • Pamidronate (Aredia) • Zoledronate (Reclast, Zometa)

☐ Prolia (Denosumab)

Do you use or have you used tobacco products?

(Circle Past or Currently per relevant mark)

- ☐ Smoking (Past/Currently)
- ☐ Snuff (Past/Currently)
- ☐ Chew (Past/Currently)
- ☐ Bidis (Past/Currently)
- ☐ Vaping (Past/Currently)

Do you drink alcoholic beverages?

☐ YES ☐ NO ☐ DK

Are you alcohol dependent?

☐ YES ☐ NO ☐ DK

Do you use or have you used prescription or street drugs or other substances for recreational purposes?

(Circle Past or Currently per relevant mark)

- ☐ Cocaine (Past/Currently)
- ☐ Ecstasy (Past/Currently)
- ☐ Heroin (Past/Currently)
- ☐ Marijuana (Past/Currently)
- ☐ Methamphetamine (Past/Currently)
- ☐ Oxycontin (Past/Currently)
- ☐ Other: (Past/Currently)

Are you drug dependent?

☐ YES ☐ NO ☐ DK

FEMALES ONLY

Are you pregnant?

☐ YES ☐ NO ☐ DK

If yes, how many weeks? _____

Are you nursing?

☐ YES ☐ NO ☐ DK

Are you taking birth control pills, fertility drugs or hormonal replacement?

- ☐ Birth Control
- ☐ Fertility Drugs
- ☐ Hormonal Replacement

Allergies: Are you allergic to or have you had a reaction to any of the following?

- ☐ Local anesthetics (Novocaine, Lidocaine)
- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ Aspirin
- ☐ Codeine or other narcotics
- ☐ Hay fever/Seasonal (allergic rhinititis)
- ☐ Metals/jewelry (nickel, chrome)
- ☐ Iodine
- ☐ Latex (rubber)
- ☐ Food/other: _____

Specify type of reaction:

_____

☐ **No Allergies**

Medications

Are you taking, have you recently (within the last month) taken, or are you supposed to be taking any medications (prescription, over the counter, diet supplements, vitamins, natural or herbal)? ☐ YES ☐ NO ☐ DK

If yes, specify medication(s), dosage and frequency: _____

Medications Prescription / Over Counter	**Dosage / Frequency**	**Supplements** Diet Supplements, Vitamins (natural or herbal)	**Dosage / Frequency**

Do you take blood thinners daily (including Aspirin)?: ☐ YES ☐ NO ☐ DK

If yes, circle: Coumadin • Xarelto • Plavix • Other: _____

Medical Conditions – Check any/all that apply

Heart/Blood Pressure Problem:

(Check any that apply)

- ☐ Rheumatic fever / Rheumatic heart disease
- ☐ Infective endocarditis
- ☐ Artificial heart valves
- ☐ Congenital heart defect
- ☐ Heart murmur
- ☐ Mitral valve prolapse
- ☐ Angina (chest pain)
- ☐ Heart attack _____ date most recent
- ☐ Heart failure
- ☐ Coronary heart disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Palpitations
- ☐ Arrhythmia (irregular heart beat)
- ☐ Shortness of breath
- ☐ Swelling of the ankles
- ☐ Pacemaker
- ☐ Implantable defibrillator
- ☐ Other: _____

Respiratory / Lung Problem

- ☐ Asthma
- ☐ Emphysema / COPD
- ☐ Tuberculosis
- ☐ Sinusitis
- ☐ Bronchitis
- ☐ Persistent cough
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Other: _____

Cancer or Tumors

- ☐ Malignant
  Location: _____
- ☐ Benign
  Location: _____

Kidney / Urinary Disorder

- ☐ Renal failure/insufficiency
- ☐ Dialysis
- ☐ Frequent urination
- ☐ Other: _____

Diabetes / Endocrine Disorder

- ☐ Diabetes
  Type 1
  Type 2
- ☐ Thyroid problems
  Hypothyroidism
  Hyperthyroidism
- ☐ Other: _____

Neurologic / Nerve Problem

- ☐ Stroke _____ date most recent
- ☐ TIA (Transient Ischemic Attack)
- ☐ Seizures/Epilepsy
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Neuropathies
- ☐ Dementia/Alzheimer's (memory loss)
- ☐ Headaches
- ☐ Fainting or dizzy spells
- ☐ Feeling of tingling or numbness
- ☐ Psychiatric disease/ Mental health disorder
- ☐ Bipolar/Manic depression
- ☐ Schizophrenia
- ☐ Depression
- ☐ ADD/ADHD (attention deficit disorder)
- ☐ Feelings of anxiety
- ☐ Feelings of depression
- ☐ Other: _____

Blood / Hematologic Disorder

- Anemia
- Sickle cell disease
- Sickle cell trait
- Bruise easily
- Leukemia
- Lymphoma
- Bleeding disorders
- Hemophilia
- Other: _____

Stomach / Intestine / Liver Disorder

- Cirrhosis/Chronic hepatitis
- Jaundice (skin/eyes turn yellow)
- Hepatitis: A B C D
  Other: _____ Circle One
- Heartburn
- Acid reflux (GERDS)
- Ulcers
- Crohn's disease
- Other: _____

Muscle / Bone / Connective Tissue Disorder

- Joint replacement
- Arthritis
  Rheumatoid
  Osteoarthritis
  Other: _____
- Osteoporosis
- Gout
- Temporomandibular Joint disorder
- Lupus
- Fibromyalgia
- Other: _____

Infectious Disease

- HIV
- AIDs
- STD (sexually transmitted disease)
  Syphilis
  Gonorrhea
  Chlamydia
  Genital herpes
  Human papillomavirus
- Cold sores
- Other: _____

Head / Eyes / Ear / Nose / Throat Problem

- Vision problems
- Glaucoma
- Hearing impairment
- Other: _____

Dermatologic / Skin Problem

Specify: _____

_____

_____

Dermatologic / Skin Problem

- Bulimia
- Anorexia
- Other: _____

Do you have any other problem, not listed above?

_____

_____

_____

_____

_____

_____

_____

For Office Use: **Is a Medical Consult Necessary:** ☐ YES ☐ NO

Height: _____ **Weight:** _____ **BMI:** _____

Patient Signature: _____ Date: _____/_____/_____

Our Payment Policy

We gladly accept payment by cash, MasterCard, Visa, American Express, Discover, and checks with proper identification.