CHANDLER CREEK
DENTAL CARE

2200 N AW Grimes Blvd Suite 100
Round Rock, TX 78665-0000
Ph: (512) 609-0066
E-MAIL: chandlercreekdentalcare@gmail.com

Patient Information

Name: _____ Gender: _____

DOB: _____ Phone: _____

Conditions

	Yes	No
Low Blood Pressure	☐	☐
Dialysis	☐	☐
Blood Thinners	☐	☐
Antibiotic Premedication for Dental Work	☐	☐
Heart Stent	☐	☐
Bleeding Disorders	☐	☐
If yes, please list your medication:		
Heart Valve Surgery	☐	☐
When was the surgery done?		
Hepatitis / Jaundice	☐	☐
Respiratory disease	☐	☐
Radiation Treatment	☐	☐
Osteoporosis Medication	☐	☐
Heart Surgery	☐	☐
What kind of surgery and when was it done?		
Chemotherapy	☐	☐
Stroke	☐	☐
Seizures	☐	☐
If yes, when was your last seizure?		
Liver Disease	☐	☐
Epilepsy	☐	☐
Heart attack	☐	☐
If yes, how many heart attacks?	☐	☐
If yes, when was your last heart attack?	☐	☐
AIDS/HIV infection	☐	☐
Alcohol/Drug Abuse	☐	☐
Rheumatic fever	☐	☐
Tuberculosis	☐	☐

	Yes	No
Fainting or dizzy spells	☐	☐
Emphysema	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
High blood pressure	☐	☐
If yes, what was your last blood pressure reading within the last three months? Any other heart trouble that you have been told about?	☐	☐
If yes, please list:		
Hepatitis A	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
Lupus	☐	☐
Cold Sores	☐	☐
Blood transfusion	☐	☐
Frequent Headaches	☐	☐
Stomach ulcers	☐	☐
Ankles swell	☐	☐
Mental Health problems	☐	☐
Anorexia/Bulimia	☐	☐
Kidney /Bladder Trouble	☐	☐
Mitral valve prolapse	☐	☐
Gall Bladder trouble	☐	☐
Blood clotting problems	☐	☐
frequent dry mouth/Sjogren syndrome	☐	☐
Cardiac pacemaker	☐	☐
Anemia	☐	☐
ADD,ADHD	☐	☐
Autism	☐	☐
Difficulty Breathing	☐	☐
Blind	☐	☐
Wheelchair bound	☐	☐
Diabetes	☐	☐
If yes, do you take insulin?	☐	☐
If yes, what was your last HbA1c value?		
If yes, have you fainted or passed out in last one year?		
Heart arrythmia	☐	☐
Hypertension	☐	☐
High Cholesterol	☐	☐
Cancer	☐	☐
Other Conditions	☐	☐

Allergies:

Allergy to NSAID	☐	☐
Allergy to Erythromycin	☐	☐
Allergy to Dental Anesthetics	☐	☐
Allergy to Metals	☐	☐
Allergy to Latex / Rubber	☐	☐
Allergy to Codeine / Narcotics	☐	☐
Allergy to Sulfa	☐	☐
Allergy to Tetracycline	☐	☐
Allergy to Aspirin	☐	☐
Allergy to Amoxicillin	☐	☐
Allergy to Keflex	☐	☐
Allergic to acrylic	☐	☐
Allergic to nitrous Oxide sedation	☐	☐
Ibuprofen	☐	☐
Other Allergies	☐	☐

Are you now under the care of a physician? * _____

Physicians name and phone number: _____

Are you in good health? _____

Have you ever had an allergic reaction that interfered with your breathing? Has there been any change in your general health within the past year? * If yes, what condition is being treated?

Have you had a serious illness, operation or been hospitalized in the past 5 years? * If yes, what was the illness or problem?_____

Is there any problem relating to your medical history that has not been mentioned? *

In case of emergency, contact and phone number? *

Are you taking or have you recently taken any prescription (including blood thinners) or over the counter medicine(s)?

Have you ever taken bone density medications such as Fosamax, Boniva ,Actonel or any additional medications containing Bisphosphonates? If so, please explain:

If yes, please list all your medications, including vitamins, natural or herbal preparations and/or dietary supplements: *

Are you taking any controlled substances including marijuana? *

Do you use tobacco in any form? If so, please explain. *

FOR FEMALE PATIENTS:{Please select one}	Yes	NO
Are you currently pregnant?	☐	☐
Are you trying to get pregnant?	☐	☐
Are you currently nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

Dental Questionnaire

What is the reason for your dental visit today?

Are you currently experiencing dental pain or discomfort?.

If yes, please explain the type of pain and area of mouth:

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

Do you have a Panoramic Xray done in last 5 years?

What factors are most important for your satisfaction with our office?

How do you feel about your smile?

Dental Information	Yes	No
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?.	☐	☐
Is your mouth dry?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐
Is your home water supply fluoridated?	☐	☐
Do you have earaches or neck pains?	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐
Do you grind your teeth?	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐
Do you wear dentures or partials?	☐	☐
Do you participate in active recreational activities?.	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐

DENTAL HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED

I CERTIFY THAT THE ANSWERS TO THE HEALTH QUESTIONS ARE ACCURATE AND CORRECT TO THE BEST OF MY KNOWLEDGE. SINCE A CHANGE OF MEDICAL CONDITION OR MEDICATIONS CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT. I UNDERSTAND THAT THE ADMINISTRATION OF LOCAL ANESTHETIC MAY CAUSE AN ADVERSE REACTION OR SIDE EFFECTS, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO BRUISING, HEMATOMA, CARDIAC STIMULATION, TEMPORARY OR RARELY, PERMANENT NUMBNESS, AND MUSCLE SORENESS. I UNDERSTAND THAT AS A RESULT OF DENTAL TREATMENT, INCLUDING PREVENTATIVE PROCEDURES SUCH AS CLEANING AND BASIC DENTISTRY,AS WELL AS FILLINGS OF ALL TYPES, TEETH MAY REMAIN SENSITIVE OR EVEN POSSIBLY QUITE PAINFUL BOTH DURING AND AFTER COMPLETION OF TREATMENT.GUMS AND SURROUNDING TISSUES MAY ALSO BE SENSITIVE OR PAINFUL DURING AND OR AFTER TREATMENT. FORTREATMENT:I, HEREBY GRANT AUTHORITY TO THE DENTISTS AT CHANDLER CREEK DENTAL CARE TO ADMINISTER ANY TREATMENT OR TO ADMINISTER SUCH ANESTHETICS,ANALGESICS, SEDATIVES AND NITROUS OXIDE SEDATION,AND TO PERFORM SUCH OPERATIONS AS MAY BE DEEMED NECESSARY OR ADVISABLE IN MY DIAGNOSIS AND TREATMENT. I HAVE READ ABOVE TERMS AND CONDITIONS AND CONSENT FOR TREATMENT AND FULLY AGREE TO THEIR CONTENT. I DO VOLUNTARILY ASSUME ANY AND ALL POSSIBLE RISKS, INCLUDING THE RISK OF SUBSTANTIAL AND SERIOUS HARM, IF ANY, WHICH MAY BE ASSOCIATED WITH GENERAL PREVENTATIVE AND OPERATIVE TREATMENT PROCEDURES IN HOPES OF OBTAINING THE POTENTIAL DESIRED RESULTS, WHICH MAY OR MAYNOT BE ACHIEVED, FOR MY BENEFIT.

Patient's /Patient representative's Initials: *

Relationship to patient: *

Self-Parent Guardian

By signing below, I certify that all the above information is true to the best of my knowledge. I understand the importance of this information and that the practice will rely on this information for treating me. I will not hold the practice or any member / staff of the practice, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient or Responsible Party

DATE: