Englewood Dental Center
3401 S Broadway
Englewood, CO 80110
Ph # : 303-444-2884
Fx # : 303-904-9419

Patient Personal Information

Title		Nickname		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				Student	SSN
Email				School Name	
				Referral Type	

Person responsible/guarantor for paying bills

Title		Nickname		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				SSN	
Email					

Do you have Primary Dental Insurance? __ Yes __ No

- Group No/Name
- Insurance Name
- Phone #
- Employer Name
- Subscriber Last, First
- Subscriber Address
- City, State, Zip
- Relationship to Patient — Birth Date
- Subscriber ID

Do you have Secondary Dental Insurance? __ Yes __ No

- Group No/Name
- Insurance Name
- Phone #
- Employer Name
- Subscriber Last, First
- Subscriber Address
- City, State, Zip
- Relationship to Patient — Birth Date
- Subscriber ID

Patient Medical Information

☐ Y ☐ N No Known Allergies

ALLERGIC TO

☐ Y ☐ N Codeine
☐ Y ☐ N Local Anesthetics
☐ Y ☐ N Oral Bisphosphonate
☐ Y ☐ N No Epinephrine
☐ Y ☐ N Tetracycline
☐ Y ☐ N latex
☐ Y ☐ N Prescription Topical
☐ Y ☐ N Percocet
☐ Y ☐ N Penicillin
☐ Y ☐ N Sulfa Drugs
☐ Y ☐ N Vicodin
☐ Y ☐ N other allergies

Check, if applicable

☐ Y ☐ N No Change Since Last Recorded

☐ Y ☐ N No Known Concerns or Issues
☐ Y ☐ N STENTS
☐ Y ☐ N AIDS/HIV Infection
☐ Y ☐ N Alcohol/Drug Abuse
☐ Y ☐ N Anemia
☐ Y ☐ N Anorexia / Bulimia
☐ Y ☐ N Arthritis
☐ Y ☐ N Asthma / Hay Fever
☐ Y ☐ N Blood Transfusion
☐ Y ☐ N Blood Thinners
☐ Y ☐ N Bronchitis
☐ Y ☐ N Cancer / Tumor or Growth
☐ Y ☐ N Cardiac Pacemaker
☐ Y ☐ N Circulatory problems
☐ Y ☐ N Damaged Heart Valve
☐ Y ☐ N Diabetes

☐ Y ☐ N Epilepsy
☐ Y ☐ N Fainting Spells / Seizures
☐ Y ☐ N Fibromyalgia
☐ Y ☐ N Gag Reflex
☐ Y ☐ N Heart Attack / Stroke
☐ Y ☐ N Heart Disease / Angina
☐ Y ☐ N Heart Murmur
☐ Y ☐ N Hepatitis / Jaundice
☐ Y ☐ N High Blood Pressure
☐ Y ☐ N Joint Replacement
☐ Y ☐ N Kidney / Bladder Trouble
☐ Y ☐ N Liver Disease
☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N Mental Health Problems
☐ Y ☐ N Nervous System /Problems
☐ Y ☐ N OSTEOPROSIS

☐ Y ☐ N Pacemaker
☐ Y ☐ N PREGNANT
☐ Y ☐ N Premedicate
☐ Y ☐ N Sexually Transmitted Disease
☐ Y ☐ N Scarlet Fever
☐ Y ☐ N Sinus Trouble
☐ Y ☐ N Thyroid Problems

Other

☐ Y ☐ N See Dental Questionnaire
☐ Y ☐ N See Medical Questionnaire
☐ Y ☐ N See Scanned Documents: Pt Note

Dental Questionnaire

Dental Questionnaire

Name of previous Dentist ______

Phone ______

Date of your last cleaning ______

Last exam date ______

Do your gums bleed while brushing or flossing ? ______

Are your teeth sensitive to hot, cold or sweets ? ______

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ? ______

Have you ever had burning of the tongue or cracking of the corners of your mouth ? ______

Have you had any head, neck or jaw injuries ? ______

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ? ______

Do you clench or grind your teeth ? ______

Have you ever had orthodontic treatment ? ______

Are you happy with your smile ? ______

Do you have an unpleasant taste or odor in your teeth/mouth ? ______

Do you want to learn to control your dental disease and retain your teeth ? ☐

Additional Comments ______

Medical Questionnaire

Medical Questionnaire

Family Physician ______

Phone ______

Are you currently under care of a Physician ? ______

If Yes, what is the condition being treated ? ______

Have you had any serious illness, operation or been hospitalized within the past 5 years ? ______

If Yes, what illness or problem ? ______

Are you currently taking any medication ? ______

If Yes, what ? ______

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) ______

Have you ever taken the diet control drug Fen-Phen ? ______

Do you use alcoholic beverages ? ______

Do you smoke ? ______

Women Only

Are you pregnant? ______

If Yes, what is your due date ? ______

Are you currently nursing ? ______

Are you on hormone replacement therapy ?	
Additional Comments	
Any Disease, Condition or Problem not Listed ? Please list	
Senior Citizen	
Are you in a wheelchair?	

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature

Date