DESERT HILLS
Cosmetic • Family • Implant
DENTAL CARE

DesertHillsDental.com

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Email: _____ Spouse Name: _____ Marital Status: _____

Social Security #: _____ Birthdate: ____/____/____ Gender: _____

Phone (Home): _____ Work: _____ Ext: _____ Cell: _____

Address: _____
Street City State Zip Code

Employer Name: _____ Occupation: _____

Employer Address: _____
Street City State Zip Code

Reason for Today's Visit: _____

In Case of Emergency Contact: _____
Name Phone

HEALTH INFORMATION

Previous Dentist (if applicable) _____ Date of Last Dental Visit: _____

Reason for **Previous Dental Visit:** _____

Have you ever had any of the following? Please check those that apply:

❑ AIDS/HIV	❑ Gastric Reflux	❑ Mental Disorders	❑ Snoring
❑ Allergies	❑ Glaucoma	❑ Nervous Disorders	❑ Stroke
❑ Anemia	❑ Headache	❑ Pacemaker	❑ Thyroid Disease
❑ Arthritis	❑ Head Injuries	❑ Low Blood Pressure	❑ Tuberculosis
❑ Artificial Joints	❑ Heart Disease	❑ Mitral Valve Prolapse	❑ Tumors
❑ Asthma	❑ Heart Murmur	❑ Radiation Treatment	❑ Ulcers
❑ Blood Disease	❑ Hepatitis A__ B__ C__	❑ Respiratory Problem	❑ Use of Tobacco
❑ Cancer	❑ High Blood Pressure	❑ Rheumatic Fever	❑
❑ Diabetes	❑ Jaundice	❑ Sinus Problems	❑
❑ Dizziness/Fainting	❑ Jaw Pain	❑ Sleep Apnea	Women: Pregnant?
❑ Epilepsy	❑ Kidney Disease	❑ Sleeping Pill Use	❑ Yes ❑ No
❑ Excessive Bleeding	❑ Liver Disease	❑ Stomach Problems	Due Date: _____

Have you ever had any complications following dental treatment? ❑ Yes ❑ No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ❑ Yes ❑ No
If yes, please explain: _____

Are you now under the care of a physician? ❑ Yes ❑ No
If yes, please explain: _____

Name of Physician: _____ Phone #: _____

Do you get nervous or anxious about receiving dental treatment? ❑ Yes ❑ No

Toll Free 866.327.4863 ◆ 505.327.4863 ◆ *Fax* 505.327.5394 ◆ 2525 East 30th Street ◆ Farmington, NM 87401

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Are you currently taking any prescription meds, over-the-counter drugs or herbal supplements? ❑ Yes ❑ No

If yes, please list them: _____

Have you ever or are you presently taking osteoporosis, anti-resorptive, or anti-cancer drugs (bisphosphonates) such as Fosamax, Actonel, Boniva, Prolia, Aredia, Zometa, Xgeva, Alendronate, Atelvia, or Reclast? ❑ Yes ❑ No

Have you ever been required to take antibiotics prior to dental treatment? ❑ Yes ❑ No

Do you have allergies or previous complications associated with dental anesthetics? ❑ Yes ❑ No

If yes, please explain: _____

Are you allergic or have you had an adverse reaction to any of the following:

❑ Aspirin ❑ Bisulfites ❑ Sulfa ❑ Penicillin ❑ PABA ❑ Latex

❑ Erythromycin ❑ Dental Anesthetics ❑ Codeine ❑ Other: _____

Do you have any health conditions that need further clarification or that we should know about? ❑ Yes ❑ No

If yes, please explain: _____

Is there anything about your smile you would like to change? Explain: _____

Please check: ❑ Whitening/Bleaching ❑ Crooked Teeth ❑ Spaces Between Teeth ❑ Replace Existing Dental Work

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? ❑ Yes ❑ No

Do you feel tired, fatigued or sleepy during the daytime? ❑ Yes ❑ No

Has anyone observed you stop breathing during your sleep? ❑ Yes ❑ No

Do you have or are being treated for high blood pressure? ❑ Yes ❑ No

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for: ❑ the patient's spouse ❑ the patient's parent ❑ the person responsible for payment

Name: _____ ❑ Male ❑ Female ❑ Married ❑ Single ❑ Child ❑ Other

Social Security #: _____ Birthdate: _____ Employer: _____

Phone (Home): _____ Work: _____ Ext: _____ Cell: _____

Address (if different): _____

Street City State Zip Code

INSURANCE INFORMATION

Primary

Name of Insured: _____ Is insured a patient? ❑ Yes ❑ No

Insured's Birthdate: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____ Insured's Social Security #: _____

Patient's Relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Plan Name and Address: _____

Secondary (if applicable)

Name of Insured: _____ Is insured a patient? ❑ Yes ❑ No

Insured's Birthdate: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____ Insured's Social Security #: _____

Insurance Plan Name and Address: _____