Botts Dental Spa

Patient Information

Date: _____ APPT.TIME_____ PREFERS A.M. / P.M

Name: _____ **Male ☐ Female ☐**

Address: _____ City, zip: _____

Home Phone: _____ Cell Phone: _____ **Married ☐ Single ☐**

Birth Date: _____ **Soc. Sec.: _____**

E-mail: _____ **Work Phone: _____**

Who referred you to our office? _____

For Insurance Purposes:
INS.CO._____ **Subscriber**:_____ **EMPLOYER**:_____
Member ID: _____ **Group #:** _____ **DOB:** _____
Soc. Sec.: _____ **Phone # for Insurance Co**.:_____
Secondary Ins.: _____**Subscriber**_____ **Employer**_____
Member ID: _____ **Group #:** _____ **DOB:** _____
Soc.Sec.::_____ **Phone # for Insurance Co**.:_____

. . . . . .

Are you teeth sensitive to:	**YES**	**S**	**NO**
Heat_____	☐	☐	☐
Cold_____	☐	☐	☐
Sweets_____	☐	☐	☐
Biting Pressure_____	☐	☐	☐
Do you drink alcohol? Y N			
Does food catch between your teeth?	☐	☐	☐
Do your gums bleed when brushing?	☐	☐	☐
Have you noticed any gum swelling around The teeth?_____	☐	☐	☐
Do you have unpleasant taste or odor in your mouth?	☐	☐	☐
Problems of the jaw:			
Clicking of the jaw R/L	☐	☐	☐
Pain (joints, ear, side of face) R/L	☐	☐	☐
Difficulty opening or closing	☐	☐	☐
Difficulty chewing	☐	☐	☐

_____
_____

Are you dissatisfied with your teeth & their appearance?

_____
_____

What is your primary reason for appointment today ?

_____
_____

Have you ever had any teeth removed? Y N
Are you interested in replacement options Y N

When was your last Dental Visit?_____
Why did you leave your last Dentist? _____
_____
_____

If you use tobacco, how much and how often?_____

Do you have anxiety about having dental procedures completed?

_____
Dr. Botts preforms oral conscious sedation dentistry for your comfort. Ask Dr. Botts or a staff member for more information today!

Are you allergic to Latex? Y or N

Do you take any antacids? Y or N

Have you ever been diagnosed with Periodontal Disease ? Y N

If you have any type of Heart problems, please explain.
_____
_____
Have you been pre-medicated for this in the past? _____

Do you have any Recurring illnesses? If so, please explain.

_____
When was your last Health Care Visit? _____

MEDICAL INFORMATION

PATIENT NAME: _____

DATE: _____

NAMES OF ALL PHYSICIANS, PHONE # AND WHY YOU ARE SEEING THEM:

_____
_____
_____
_____
_____
_____

NAMES OF ALL MEDICATIONS, DOSAGE AND WHY YOU ARE TAKING THEM:

_____
_____
_____
_____
_____
_____

IF YOU NEED MORE ROOM USE THE BACK OF THIS FORM.

WEIGHT AND DIET CONSIDERATIONS:

Weight:_____, Meals per day:_____,

Dietary Restrictions:_____

Food Allergies:_____

Sugar in your diet (circle one) none slight moderate high

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	Yes No	If yes
Other?	☐	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
Yellow Jaundice Yes No			

Have you ever had any serious illness not listed	Yes No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____