Sleep Dentistry℠ of VANCOUVER | EAST

Patient information:

Last name:	First name:	Middle:	Suffix *(check)*: ☐ Sr ☐ Jr ☐ I ☐ II ☐ III	Pronoun:
Address:	City:	State:	Zip code:	Preferred Name:
Mailing address *(if different)*:				Date of birth *(mm/dd/yyyy)*:
Cell phone:	Home phone:	Work phone:		SSN:
Email address *(email is not secure)*:				
Emergency contact:	Relationship:			Phone number:

Parent or Guardian, if patient is a minor:

Name of parent or guardian *(last, first)*:		Relationship:	
Mailing address *(if different)*:	City:	State:	Zip code:
Cell phone:	Home phone:	Work phone:	
Email address *(email is not secure)*:			

Medical Information:

Primary care physician: City/State: Phone number:

Are you currently under a doctor's care? *(check)* ☐ **yes** ☐ **no** If yes, please explain:

Has your MD or DMD recommended premedication with antibiotics prior to procedures? *(check)* ☐ **yes** ☐ **no** If yes, please explain:

Do you have any known allergies? *(check)* ☐ **yes** ☐ **no** If yes, please explain allergy reaction:

Have you ever taken any Bisphosphonate medications? (check) ☐ **yes** ☐ **no**

If yes, please (check): ☐ **Actonel** ☐ **Fosamax** ☐ **Zometo** ☐ **Didronel** ☐ **Boniva** ☐ **Skelid** ☐ **Aredia** ☐ **Bonefos** ☐ **Reclast** ☐ **other** _____

Please explain what the medication was taken for: _____

Dosage/Frequency: _____

(Women only) Are you pregnant or trying to conceive? *(check)* ☐ **yes** ☐ **no** If yes, **due date:** _____ Are you nursing? *(check)* ☐ **yes** ☐ **no**

Are you taking oral contraceptives ☐ **yes** ☐ **no**

Substance use and history:

Do you use tobacco? ☐ **yes** ☐ **no** *(check)*: ☐ **current** ☐ **past** ☐ **never**

If current, how often and type? _____ How many years of use? _____ If past, quit date? _____

Current prescription and over the counter medications:

Note: If you need additional space or if you are providing a separate list or document please check box ☐

Medication	Dosage	Frequency	Reason for taking medication

Do you have or have you experienced any of the following medical conditions? Please check all that apply

Heart/Blood Pressure Problems

- ☐ Heart Disease
  - If yes, type: _____
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Ineffective Endocarditis
- ☐ Rheumatic Fever
- ☐ Artificial Heart Valve
- ☐ Heart Murmur
- ☐ Arrhythmia
- ☐ Pacemaker
- ☐ Implantable Defibrillator
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Other: _____

Respiratory/Lung Problems

- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Sleep Apnea
- ☐ Other: _____

Endocrine Disorders

- ☐ Diabetes
  - if yes, type: _____
  - Last HbA1c Reading
  - Date Taken: _____
- ☐ Insulin Pump
- ☐ Thyroid Disease
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Parathyroid Disease
- ☐ Other: _____

Kidney/Liver Disease

- ☐ Kidney Disease
- ☐ Dialysis
- ☐ Hepatitis
  - if yes, type: _____
- ☐ Liver Disease
- ☐ Cirrhosis
- ☐ Other: _____

Blood Disorders

- ☐ Anemia
- ☐ Bleeding Disorder
  - if yes, type: _____
- ☐ Blood Thinners
- ☐ High Cholesterol
- ☐ Other: _____

Stomach/Intestine Disorders

- ☐ Special Diet
  - if yes, type: _____
- ☐ Ulcers
  - if yes, location: _____
- ☐ Acid Reflux
- ☐ Crohn's Disease
- ☐ Other: _____

Infectious Diseases

- ☐ HIV/AIDS
- ☐ MRSA *(check)* Active Inactive
  - if yes, location: _____
- ☐ Cold Sores
- ☐ Human Papillomavirus (HPV)
- ☐ Tuberculosis
  - If yes, date treatment ended:
  - _____

Neurologic/Psychiatric Problems

- ☐ Stroke
  - if yes, date: _____
- ☐ TIA (transient ischemic attack)
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Alzheimer's Disease
- ☐ Dementia
- ☐ Anxiety
- ☐ Dental Anxiety
- ☐ Depression
- ☐ Post-Traumatic Stress Disorder
- ☐ Epilepsy or Seizures
- ☐ Autism Spectrum Disorder
- ☐ ADHD/ADD
- ☐ Bipolar
- ☐ Schizophrenia
- ☐ Psychosis
- ☐ Migraines
- ☐ Fainting or Dizzy Spells
- ☐ Other: _____

Cancer/Oncology

- ☐ Cancer
  - if yes, type: _____
- ☐ Chemotherapy
  - if yes, date: _____
- ☐ Radiation Therapy
  - if yes, date: _____

Muscle/Bone/ Connective Tissue Disorders

- ☐ Artificial Joints
  - Joint: _____
  - Date Placed: _____
- ☐ Arthritis
  - if yes, type: _____
- ☐ Osteoporosis
- ☐ Gout
- ☐ Temporomandibular Joint Disorder
- ☐ Fibromyalgia
- ☐ Other: _____

Head/Ear/Nose/Throat Problem

- ☐ Vision Problems
- ☐ Wear Contact Lenses
- ☐ Glaucoma
- ☐ Hearing Impairment
- ☐ Seasonal Allergies
- ☐ Sinus Problems
- ☐ Other: _____

Eating Disorders

- ☐ Bulimia
- ☐ Anorexia
- ☐ Other: _____

Other

- ☐ Transplanted Organ(s)
- ☐ Implantable Medical Electronic Device
  - if yes, type: _____

If you checked any of the boxes above or if you have experienced any medical conditions not included above, please use the space below to provide more information.

_____

_____

I acknowledge that all charges for services rendered are my responsibility. Balances over 30 days will be subject to a 1.5% monthly charge (18% per annual). A fee of $50 will be applied to all returned checks. Any cancellation or rescheduling of an appointment, requires 48 business hour notice, to avoid a minimum fee of $75 per appointment hour.

SIGNATURE _____ DATE _____

PRACTITIONER _____ DATE _____