MONTANO dental

Stacey Montano DDS
3901 Georgia St NE Bldg. G1
Albuquerque, NM 87110
505-888-3112
www.montanodental.com

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. Thank you.

Patient Name: _____ Date of Birth: _____ Sex: _____ Age: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Billing Address (if different):_____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

SS#: _____Employer/Occupation: _____

Emergency contact: _____ Emergency phone #: _____

Primary Dental Insurance: _____ Group #: _____

Secondary Dental Insurance: _____ Group #: _____

Subscriber's Name: _____ Date of Birth: _____ SS #: _____

Name of medical doctor: _____ Date of last visit to medical doctor: _____

Name of previous dentist: _____ Date of last dental visit: _____

Email:_____ Referred to us by: _____

Dental Health History

	Yes	No		Yes	No
Are you apprehensive about dental treatment?	☐	☐	How often do you brush? _____		
Have you had problems with previous dental treatment?	☐	☐	How often do you floss? _____		
Do you gag easily?	☐	☐	Does your jaw make noise that bothers you or others?	☐	☐
Do you wear dentures?	☐	☐	Do you clench or grind frequently?	☐	☐
Does food catch between your teeth?	☐	☐	Does your jaw ever feel tired?	☐	☐
Do you have difficulty in chewing your food?	☐	☐	Does your jaw get stuck so that you can't open freely?	☐	☐
Do you chew on only one side of your mouth?	☐	☐	Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you avoid brushing any part of your mouth due to pain?	☐	☐	Do you have earaches or pain in front of the ears?	☐	☐
Do your gums bleed easily?	☐	☐	Do you have any jaw symptoms or headaches upon awaking in the morning?	☐	☐
Do your gums bleed when you floss?	☐	☐			
Do your gums feel swollen or tender?	☐	☐	Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	☐	☐
Have you ever had slow-healing sores in or about your mouth?	☐	☐	Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Are your teeth sensitive?	☐	☐	Do you have temporomandibular (jaw) disorder (TMD)?	☐	☐

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	Yes	No
Do you feel twinges of pain when your teeth contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with appearance of your teeth?	☐	☐

	Yes	No
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Are you a habitual gum chewer?	☐	☐
Do you want complete dental care?	☐	☐

Medical Health History

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

	Yes	No
Heart Problems	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood tranfusion?	☐	☐
Allergy Problems	☐	☐
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medications	☐	☐
Asthma	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or bladder problems	☐	☐

	Yes	No
Diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
If so, how much?		
Do you smoke?	☐	☐
If so, how much?		
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive / AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐

Do you have any disease, condition, or problem not listed previously that you feel we should know about?

If so, please describe:

Are you or have you ever taken bisphosphonates or any drug for osteoporosis? ☐ ☐

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Medical Health History

	Yes	No
Bone or Joint Problems	☐	☐
Arthitis	☐	☐
Back or neck problem	☐	☐
Jont replacement (e.g. total hip, pins, or implants)	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Strokes	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Premedications required by physician	☐	☐
Cancer/Tumor	☐	☐

Are you allergic or have you reacted adversely to any of the following?

Local anesthetics ("Novacaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or ibuprofen	☐	☐
Codeine, Demorol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐

Other_____

During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g. Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Asprin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drug/supplements	☐	☐

List all current medications_____

_____

_____

_____

Women	Yes	No
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐

If so, do you have any symptions?_____

I certify that the information I have provided is true and complete to the best of my knowledge. I have advised you of all medical problems of which I am aware, and I will inform you of any future changes. I hereby consent to the administration of anesthesia and the dental treatments specified at this office.

CONDITIONS OF PAYMENT

- I agree that parents are responsible for all fees and services rendered for the treatment of a child.
- I understand that I am responsible for ALL fees regardless of insurance coverage. I also understand as treatment progresses, fees and treatment may have to be adjusted.
- In the event of a past due account I agree to pay all costs of collections, including, but not limited to, reasonable attorney's fees.
- Appointment cancellations made with less than a 24 hour notice may incur a cancellation fee of $30.00.

Patient's Signature _____ Date_____

Guardian or Parent's Signature _____ Date_____