Pursuing the Perfect Smile

**Stephen G. Petinge, D.M.D.**

*Complete Esthetic Dentistry*

# MEDICAL HISTORY

Name: _____

Email: _____

Best contact # _____

Describe chief dental concern: _____

| Please mark either: | Yes | No |
|---|---|---|
| Are you experiencing dental pain? | ☐ | ☐ |
| Do you clench or grind your teeth? | ☐ | ☐ |
| Do you have any jaw pain? | ☐ | ☐ |
| Have you had a poor experience with dentistry? | ☐ | ☐ |
| Are you interested in saving your teeth? | ☐ | ☐ |
| Do your gums bleed when chewing or brushing? | ☐ | ☐ |
| Are you pleased with the appearance of your teeth? | ☐ | ☐ |
| Are you deeply concerned about the finances required to return your mouth to excellent dental health? | ☐ | ☐ |

If you could change anything about your teeth, what would you change? _____

_____

Are you currently taking, or have you ever taken, any bisphosphonates? ☐ ☐

If yes, for how long? _____

Are you under the care of a physician? ☐ ☐

Why? _____

_____

List any medications, prescribed or self administered:

_____

_____

_____

DOB: _____

Do you have or have you had any of the following:

| | Yes | No |
|---|---|---|
| Mitral Valve Prolapse | ☐ | ☐ |
| Heart Disease | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ |
| Angina (chest pain) | ☐ | ☐ |
| Artificial Joint Replacement | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Kidney Trouble | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |
| Malignancies (cancer) | ☐ | ☐ |
| AIDS or any related illness (HIV Virus) | ☐ | ☐ |
| Asthma or Emphysema | ☐ | ☐ |
| Productive Cough or Recent Cold | ☐ | ☐ |
| Hayfever, Allergies or Hives | ☐ | ☐ |
| Liver Disease, Jaundice, Hepatitis | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ |
| Epilepsy, Seizures, Convulsions | ☐ | ☐ |
| Difficulty in Hearing or Eye Disease | ☐ | ☐ |
| Psychiatric or Nervous Disorders | ☐ | ☐ |
| Do you smoke? If so how many packs per day ____ | | |
| Sinus Trouble | ☐ | ☐ |
| Excessive or Prolonged Bleeding | ☐ | ☐ |
| Anemia or Blood Disorder | ☐ | ☐ |
| Latex Allergy | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ |
| Osteopenia | ☐ | ☐ |
| Do you have allergies to any Medications? | ☐ | ☐ |

List Medications you have allergies to:

_____

_____

Past Surgeries (last 5 years) _____

_____

| | | |
|---|---|---|
| Pre Medication required by Physician? | ☐ | ☐ |

WOMEN

| | | |
|---|---|---|
| Are you taking medication for osteoporosis? | ☐ | ☐ |
| Pregnant? If so what month? | ☐ | ☐ |
| Are you taking birth control pills? | ☐ | ☐ |

THE ABOVE MEDICAL HISTORY IS TRUE TO THE BEST OF MY KNOWLEDGE, AND I CONSENT TO ROUTINE PROCEDURES DEEMED NECESSARY FOR DIAGNOSIS AND TREATMENT.

Signature of Patient or Guardian _____ Date _____

Patterson #200096280

## RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____

RESIDENCE Street _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ City _____ State _____ Zip _____

HOME PHONE _____ CELL PHONE _____ WORK PHON E _____

E-MAIL ADDRESS _____ SOCIAL SEC URITY# _____

BIRTHDATE _____ DRIVER'S LICENSE# _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

## RESPONSIBLE PARTY'S SPOUSE

NAME _____
LAST FIRST MIDDLE

EMPLOYER _____ NO. YEARS EMPLOYED _____

OCCUPATION _____ SOC. SEC.# _____

WORK PHONE _____ BIRTHDATE _____

## EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____

ADDRESS _____

CITY, STATE _____ PHONE _____

## DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec# _____ Group# _____ Local # _____

## If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec# _____ Group# _____ Local # _____

***PLEASE READ AND SIGN THE FOLLOWING RESPONSIBILITY AND CONSENT STATEMENT:**
To the best of my knowledge, the above information is complete and correct. **I understand that I am responsible for any financial obligation incurred for the services provided.** I also authorize and request the performance of dental services for myself or my minor child and give my consent to any advisable and necessary dental procedures, medication, anesthetics or analgesics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment. (You will be informed of planned services before services are rendered.)

DATE: _____ SIGNATURE: _____
(parent or guardian if patient is a minor)

# Sleep Health History

Patient Name: _____ DOB: _____

## Associated Comorbidities

| | | | | | |
|---|---|---|---|---|---|
| Hypertension<br>*High Blood Pressure* | Y | N | Heart Disease | Y | N |
| | | | Mood Disorders | Y | N |
| History of Stroke | Y | N | Insomnia | Y | N |
| Type 2 Diabetes | Y | N | Impaired Cognition | Y | N |

## Epworth Sleepiness Scale

Scoring: 0 = No chance of dozing or sleeping, 1 = Slight chance of dozing or sleeping, 2 = Moderate chance of dozing or sleeping, 3 = High chance of dozing or sleeping

| | | | | |
|---|---|---|---|---|
| Sitting and reading | 0 | 1 | 2 | 3 |
| Watching TV | 0 | 1 | 2 | 3 |
| Sitting inactive in a public place | 0 | 1 | 2 | 3 |
| As a passenger in a car for an hour without a break | 0 | 1 | 2 | 3 |
| Lying down to rest in the afternoon | 0 | 1 | 2 | 3 |
| Sitting and talking to someone | 0 | 1 | 2 | 3 |
| Sitting quietly after a lunch without alcohol | 0 | 1 | 2 | 3 |
| In a car, while stopped for a few minutes in traffic | 0 | 1 | 2 | 3 |

Total _____

Patient Signature: _____ Date: _____

Stephen G Petinge DMD

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

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