The Village Dental Center
13802 W. Camino Del Sol, Sun City West, AZ 85375
(623)583-0151

Welcome to our office. We sincerely appreciate you choosing our office for your dental care needs. Please be assured that we will work hard to continually earn the trust you have placed in us. In order for us to serve you better, please take several minutes to complete this information as thoroughly as possible.

PATIENT INFORMATION

Name _____ Date of Birth ____/___/____

Social Security Number _____-_____-_____ Sex Male or Female

Address _____ City/State _____ Zip Code _____

Home Phone _____ E-Mail Address _____

Who may we thank for referring you to us for care? _____

EMPLOYER INFORMATION

Employer Name _____ Work Number _____

Employer Address_____ City/State _____ Zip Code _____

INSURANCE INFORMATION (disregard this section if you have an insurance card available to copy)

Employed By/Retired From _____

Name of Insurance Co _____ Plan Name/Number _____

Name of Insured Person _____ Group Number _____

Social Security # of Insured _____ Insured Date of Birth ___/___/____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____

Phone _____

PREFERRED PHARMACY

Name _____

Address/Cross Streets _____

As a condition of your treatment by this office, the patient understands that they are personally responsible for payment of all dental services at the time services are preformed; with the exception of Delta Dental whose fees will be estimated.

As a courtesy to all our patients we will continues to submit all necessary paperwork, narratives and x-rays when applicable to help expedite the processing of your claims in order for you to get the reimbursement you deserve. All insurance payments will be sent to you directly with the exception of those with Delta Dental insurance coverage. We do not accept assignment of benefits from any insurance company other than Delta Dental.

This dental office cannot render services on the assumptions that our charges will be paid by an insurance company. I have read the above conditions of treatment and payment and agree to their content.

_____ _____

Signature of Patient/Guardian **Today's Date**

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DENTAL HISTORY

Please describe your chief complaint

_____

_____

Are your teeth sensitive to (please circle yes or no)

Heat Yes/No Cold Yes/No Sweets Yes/No Chewing Yes/No

Do you have food traps? Yes/No

Do your gums feel swollen or tender? Yes/No

Do your gums bleed when brushing? Yes/No

Do you use dental floss? Yes/No

Do you have any teeth that feel loose? Yes/No

Do you lose or break fillings? Yes/No

Have you ever been treated for periodontal disease or gum disease? Yes/No

Have you had any previous injuries to your face or jaws? Yes/No

Do you clench or grind your teeth? Yes/No

Do your jaws ever feel tired or ache? Yes/No

Have you had a complete dental exam including full mouth x-rays, in the past 3 years? Yes/No

Have you had your teeth cleaned regularly? Yes/No

When was your last cleaning? _____

Do you have all or most of your natural teeth? Yes/No

If you've had teeth removed, have they been replaced? Yes/No

What do you like about your smile?

_____

_____

If you could improve your teeth/smile, what would you do?

_____

_____

Do you consider yourself a nervous dental patient? Yes/No

Have you ever had an unpleasant dental experience? Yes/No

When was your last dental appointment? _____

What was done at your last visit?

_____

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MEDICAL HISTORY

Your Name _____ Today's Date _____

Physician's Name _____ Phone # _____

When was your last visit to your physician? ___/___/____

When was your last complete physical? ___/___/____

Are you a current or past tobacco user? _____

Please tell us if you have had any of the following by checking the appropriate box

○ Bacterial Endocarditis	○ Congestive Heart Failure	○ Immunosuppressive Disorders/ARC	○ Cancers, Tumors, Growths
○ Heart Murmur	○ Hemophilia	○ Any Artificial Replacements	○ Diabetes
○ Irregular Heart Beat	○ Blood Disease	○ Kidney Problem	○ Dialysis
○ Liver Problems	○ Hepatitis	○ Stroke	○ Thyroid Problems
○ Ulcer/Colitis	○ High Blood Pressure	○ Low Blood Pressure	○ Rheumatic Heart Fever
○ Rheumatic Heart Disease	○ Artificial Heart Valves	○ Congenital Heart Lesion	○ Mitral Valve Prolapse
○ Heart Attack ____ Year	○ Angina/Chest Pain	○ Heart Pacemaker	○ Heart Surgery
○ Blood Disease	○ Anemia/Blood Problems	○ Excessive Bleeding	○ Asthma
○ Respiratory Disease	○ Shortness of Breath	○ Hay Fever	○ Sinus Problems
○ Tuberculosis	○ Eye Disorders/Glaucoma	○ AIDS	○ Rheumatism/Arthritis
○ Neurological Problems	○ Epilepsy/Seizures	○ Alcoholism	○ Chemical Dependency
○ Drug Addiction	○ Malignancies	○ Sexually Transmitted Diseases	○ Fever Blisters

Please list any other MEDICAL CONDITIONS not mentioned above

_____

Have you had any surgeries or serious illnesses?

_____

_____

Do you have any current allergies?

_____

○ Codeine Allergy	○ Penicillin Allergy	○ Latex Allergy

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CURRENT MEDICATIONS

Name of Drug _____
Strength and Frequency _____ Reason _____

Name of Drug _____
Strength and Frequency _____ Reason _____

Name of Drug _____
Strength and Frequency _____ Reason _____

Name of Drug _____
Strength and Frequency _____ Reason _____

Name of Drug _____
Strength and Frequency _____ Reason _____

Name of Drug _____
Strength and Frequency _____ Reason _____

Name of Drug _____
Strength and Frequency _____ Reason _____

Name of Drug _____
Strength and Frequency _____ Reason _____

_____ _____

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BISPHOSPHONATE ALERT

A connection between *Fosamax* and other bisphosphonates, with a serious bone disease called *Bisphosphonates Related Osteonecrosis of the Jaw* (ONJ) has been found. The research is inconclusive on exactly how Bisphosphonates affect ONJ and how frequently the condition is found.

Bisphosphonates are commonly used in tablet form to **prevent and treat osteoporosis** in post-menopausal woman and older men. They are also used in the treatment of Paget's disease. Stronger forms given orally intravenously (IV) are commonly used in the management of advanced cancers including, but not limited to, lung cancer, breast cancer, prostate cancer, multiple myeloma, and other matatsic cancers.

HAVE YOU EVER TAKEN ANY OF THE FOLLOWING BISPHOSPHONATES?
Oral Medications
Alendronate (Fosamax ®) Merck & Co? Yes/No
Alendronate (Fossamax Plus D®) Merck & Co? Yes/No
Ibandronate (Boniva®) Roche Laboratories? Yes/No
Risedronate (Actonel®) Proctor & Gamble? Yes/No
Tiludronate (Skelid®) Sanofi Pharmaceuticals? Yes/No
Etidronate (Didronel®) Proctor & Gamble? Yes/No
Zoledronate (Reclast®) Novartis (annual infusion)? Yes/No

Have you ever been treated for cancer with chemo therapy in the past? Yes/No

Intravenous Medications (chemo therapy)
Pamidronate (Aredia®) Novartis? Yes/No
Zoledronate (Zometa ®) Norartis? Yes/No
Clondronate (Bonefos®) Sherling AG? Yes/No

If yes, when? _____
Prescribing Doctor _____

_____ _____
Signature of Patient/Guardian **Today's Date**