Anantuni FAMILY DENTAL

5590 W Chandler Blvd #1
Chandler, AZ 85226
P: 480-821-4000
F: 480-893-7764

Welcome To Our Office!

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name _____ Todays Date _____

Soc. Sec. # _____ Birthdate_____ Home Phone_____ Cell #_____

Address_____ City_____ State _____ Zip _____

Email _____ Driver's License # _____

When confirming appointments how do you prefer to be contacted? ☐ Phone ☐ Email ☐ Text Message

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City_____ State_____ Zip_____

Spouse or Parent's Name _____ Employer _____ Work Phone_____

How did you hear about our office? (Check All That Apply)

☐ Google ☐ Yelp ☐ Website ☐Insurance Company ☐ Drive By ☐ ZocDoc ☐ Facebook

☐ Friend _____ ☐ Patient _____

Responsible Party

Responsible Party for this Account _____ Relationship to Patient _____

Phone # _____ Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Emergency Contact (Please list "TWO" different contacts)

Primary contact: _____ Phone# _____Relation:_____

Secondary contact: _____Phone#_____Ralation:_____

Insurance Information (policy holder)

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ ID# _____

Name of Employer_____ Work Phone_____

Insurance Company _____Group #_____ Phone #_____

Secondary Insurance

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ ID# _____

Name of Employer_____ Work Phone_____

Insurance Company _____Group #_____ Phone #_____

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Patient Medical History

Physician _____Office Phone_____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐

If yes, please explain _____

3. Are you taking any medication(s) including non-prescription medicine?	☐	☐

If yes, what medications are you taking? _____

4. Are you currently taking or have you ever taken osteoporosis medications in the past?	☐	☐

If so, how long? _____ Which ones? _____

5. Do you use any tobacco products?	☐	☐

If so, how long? _____ _ Which ones? _____

6. Do you use controlled substances or recreational drugs?	☐	☐

If yes, which ones (including medical marijuana) and how often? _____

7. **Are You Allergic to:**	Yes	No		Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐	Iodine	☐	☐
Penicillin	☐	☐	Aspirin	☐	☐
Sulfa Drugs	☐	☐	Ibuprofen	☐	☐
Other Antibiotics _____	☐	☐	Codeine	☐	☐
Latex Rubber	☐	☐	Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Sedatives	☐	☐	Other _____	☐	☐

8. **Women Only:**	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐

When are you due? _____ Who is your OB/GYN? _____ Phone# _____

b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

9. **Do you have or have you had any of the following?**

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Seizures/Epilepsy	☐	☐	Anemia	☐	☐
Low Blood Pressure	☐	☐	Cancer	☐	☐	Emphysema/COPD	☐	☐
Heart Disease	☐	☐	Type _____			Tuberculosis	☐	☐
Angina	☐	☐	Radiation Therapy	☐	☐	Asthma	☐	☐
Heart Attack	☐	☐	When _____			Arthritis	☐	☐
When? _____			Diabetes	☐	☐	Joint Replacement	☐	☐
Cardiac Pacemaker	☐	☐	Type _____			When _____		
Mitral Valve Prolapse	☐	☐	Kidney Diseases	☐	☐	Neck/Back Pain	☐	☐
Heart Murmur	☐	☐	Liver Disease	☐	☐	When _____		
Congestive Heart Failure	☐	☐	Thyroid Problem	☐	☐	Glaucoma	☐	☐
Rheumatic Fever	☐	☐	Ulcers	☐	☐	Sight Impaired	☐	☐
Stroke	☐	☐	Hepatitis/Jaundice	☐	☐	Hearing Impaired	☐	☐
Vertigo	☐	☐	AIDS or HIV Infection	☐	☐	Hay Fever/Allergies	☐	☐
Fainting	☐	☐	STD's	☐	☐	Other _____		

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Patient Dental History

Name of Previous Dentist_____ **Date of Last Exam/Cleaning** _____

		Yes	No
1.	Do you like your smile? What would you change? _____	☐	☐
2.	Do your gums bleed while brushing or flossing?	☐	☐
3.	Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
4.	Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
5.	Do you feel pain on any of your teeth?	☐	☐
6.	Do you have any sores or lumps in or near your mouth?	☐	☐
7.	Have you had any head, neck or jaw injuries?	☐	☐
8.	Have you ever experienced any of the following problems in your jaw?	☐	☐
	Clicking	☐	☐
	Pain (joint, ear, side of face)	☐	☐
	Difficulty in opening or closing	☐	☐
	Difficulty in chewing	☐	☐
9.	Do you have frequent headaches?	☐	☐
10.	Do you clench or grind your teeth?	☐	☐
11.	Do you bite your lips or cheeks frequently?	☐	☐
12.	Have you ever had any difficult extractions in the past?	☐	☐
13.	Have you ever had any prolonged bleeding following extractions?	☐	☐
14.	Have you had any orthodontic treatment?	☐	☐
15.	Do you wear dentures or partials? If yes, date of placement_____	☐	☐
16.	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐

(*Office use only) BP: _____ **P:** _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I agree to be responsible for payment of all service rendered on my behalf of my dependents.

Print Name of Patient _____ **Preferred Name** _____

***Signature of Patient** _____ **Date** _____

Doctor's Signature _____ **Date** _____

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