Daniel R Pestana DDS

Thank you for filling out this form completely. It will enable our office to be more effective in meeting your needs. If you have any questions at any time, please ask us. We will be happy to help.

Name **Birthdate:** **Phone#**

Why have you come to the Dentist today?

Dental History

Do you require antibiotics before dental work?

Are you currently in pain?

Do your gums ever bleed?

Do your Gums Itch?

Have you experienced problems associated with any previous dental work?

Have you ever had periodontal disease?

Do you have frequent headaches?

Does food get caught between your teeth?

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ?TMD)?

Are your teeth sensitive to heat, cold, or anything else?

Your current dental health is?

Do you floss daily?

Do you brush daily?

What type of bristles on your toothbrush?

How long do you use a tooth brush before replacing it?

Do you use anything in addition to your brush and floss?

If you use anything in addition to your brush and Floss what do you use?

Do you still have your wisdom teeth?

Do you have any loose teeth?

Have you lost any teeth?

If you have lost teeth why?

Medical History

Do you have a personal Physician?

Physician's Name:

Physician's Phone Number:

Your current Physical health is?

Physician's Address:

Date of last visit?

Are you currently under the care of a physician?

If you are currently under the care of a physician please explain?

Are you happy with the way your smile looks?

If you are not happy with the way your smile looks, what would you change?

Do you Smoke or use tobacco in any other form?

Have you ever had a blood transfusion?

If yes When?

Have you ever taken Fen-Phen or Redux?

If so when did you take Fen-Phen or Redux?

Are you taking or schedule to begin taking Alendronate (Fosamax) or Risedronate(Actonel) for osteoporosis or Paget's disease?

FOR WOMEN:

Are you taking birth control pills?

Are you Pregnant?

weeks

Are you Nursing?

Are you allergic to any of the following? Please check Box.

Aspirin ☐ Codeine ☐ Erythromycin ☐ Latex ☐ Sedatives ☐ Tetracycline ☐

Barbiturates ☐ Dental Anesthetics ☐ Jewelry ☐ Penicillin ☐ Sulfa Drugs ☐ Other ☐

Please list additional drugs/substances that cause allergic reactions:

Since 2011, were you treated or are you presently schedule to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hyperclacemia or skeletal complications resulting from Pagent's disease, multiple myeloma or metastatic cancer?

Are you taking any of the following?

Acetaminophen ☐ Antihistamines ☐ Blood Pressure Medication ☐ Cold Remedies ☐ Herbal Supplements ☐ Steroids/ Cortisone ☐

Antibiotics ☐ Aspirin ☐ Blood Thinners ☐ Digitalis/ Heart Medication ☐ Insulin/Diabetes Drugs ☐ Thyroid Medicine ☐

Recreational Drugs ☐ Nitroglycerin ☐ Tranquilizers ☐

Are you taking any prescription/over-the-counter or Herbal supplement drugs not listed above? If yes, Please list each one:

Health History:

Do you have any of these conditions please check box:

Abnormal Bleeding ☐	Chemotherapy ☐	Fainting Spells ☐	Hepatitis ☐	Pacemaker ☐	Sickle Cell Disease ☐
Alcohol Abuse ☐	Chicken Pox ☐	Fever Blister ☐	Herpes / Fever Blisters ☐	Persistent Cough ☐	Sinus Problems ☐
Anemia ☐	Colitis ☐	Frequent Headaches ☐	High Blood Pressure ☐	Psychiatric Problems ☐	Steroid Therapy ☐
Arthritis ☐	Congenital Heart Defect ☐	Glaucoma ☐	HIV+ / AIDS ☐	Radiation Treatment ☐	Stroke ☐
Asthma ☐	Diabetes ☐	Hay Fever ☐	Hospitalized for Any Reason ☐	Rheumatic Fever ☐	Thyroid Problems ☐
Artificial Bones/Joints ☐	Difficulty Breathing ☐	Heart Attack ☐	Kidney Problems ☐	Scarlet Fever ☐	Tonsillitis ☐
Artificial Valves ☐	Drug Abuse ☐	Heart Murmur ☐	Liver Disease ☐	Seizures ☐	Tuberculosis (TB) ☐
Blood Transfusion ☐	Emphysema ☐	Heart Surgery ☐	Low Blood Pressure ☐	Severe Headaches ☐	Ulcers ☐
Cancer ☐	Epilepsy ☐	Hemophilia ☐	Mitral Valve Prolapse ☐	Shingles ☐	Venereal Disease ☐

Please list any serious medical condition(s) that you have experienced:

I affirm that the information I have given today is correct to the best of my Knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature Date:

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. My method of pay will be:

I, (your name) ,consent to be a patient at Dr. Daniel R. Pestana DDS and agree to a radiographic and clinical examination.

I also understand and consent to the following:

1. During the course of treatment, I may undergo procedures in all Phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve un anticipated results.

4. I will pay in full any cost of treatment or insurance co-payments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved, I am responsible for any costs that my insurance does not cover.

5. My treatment plan may change any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

Signature **Date**

Witness **Date:**