



SMILES of ST. GEORGE
 PATRICK H. BONDAD, DDS
the art of exceptional dentistry

I have read or received a copy of this office's
 Notice of Privacy Practices.

 Patient/parent/guardian signature Date

address 352 E Riverside Drive, Ste C2, St. George UT 84790 phone 435-688-7171 website www.smilesfstgeorge.com

Thank you for selecting our dental team!

The information you provide in these forms is kept **confidential** and will help us provide the best dental care we know how.

Patient Information

Today's Date: _____

Patient name: _____ Preferred Name: _____

Gender: Male Female Family Status: Single Married Child Other _____ DOB: _____

Phone #'s (Home) _____ (Work) _____ Ext: _____

Email: _____ (Cell #/ pgr) _____ Best time to call: _____

Where do you prefer to receive calls? Home Work Cell

Social Security number: _____ Driver's Lic. or State ID #: _____

Home Address: _____
Street Apartment # City State Zip

Mailing Address (if different) _____
Street City State Zip

Employer: _____ Address: _____

Occupation: _____

Spouse's Name: _____

In case of an emergency, who should we contact? _____ Relationship: _____

Emergency contact phone numbers: _____

How did you hear about our practice? _____

Insurance Information

Primary Dental Coverage:

Name of the Insured/Policy holder: _____ Is insured a patient? Y N

Insured's Birth Date: _____ SSN or Subscriber ID# _____

Patient's relationship to insured: Self Spouse Child Other _____

Ins. Company / Plan Name _____ Group #: _____

Ins. Company / Plan Address _____ Ins. Co. Phone #: _____

Secondary Dental Coverage:

Name of the Insured/Policy holder: _____ Is insured a patient? Y N

Insured's Birth Date: _____ SSN or Subscriber ID# _____

Patient's relationship to insured: Self Spouse Child Other _____

Ins. Company / Plan Name _____ Group #: _____

Ins. Company / Plan Address _____ Ins. Co. Phone #: _____

Health Information

We understand that you are here for us to help you with your health. Medications you are taking and health problems you could make a difference in how we treat your dental problems. Thank you for your assistance.

Physician Name _____ Phone Number _____

Medical Specialist Name _____ Phone Number _____

(Cardiologist, Orthopedist, Internist, etc)

Are you currently under the care of a physician? Yes No

If yes, for what? _____

When did you last visit your physician? _____

You consider your health to be: Excellent Good Fair Poor

Do you have recent blood tests including HbA1C, C-reactive protein, cholesterol, blood lipids, etc. (Pls. provide a copy.)

If yes, with whom, when: _____

Medications

Please list what medications you are taking, including “over the counter”, (i.e. aspirin, vitamins, etc.)

Are you allergic to any of the following? Please circle yes or no:

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Metal/Jewelry	<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Dental Anesthetics	<input type="checkbox"/> Latex	Other: _____

Do you have or ever had any of the following conditions: Please circle yes or no

Heart Problems

<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Congenital heart defect	<input type="checkbox"/> Angina	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Stroke	<input type="checkbox"/> Anemia
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Heart (Attack, Surgery)

Bleeding

<input type="checkbox"/> Excessive bleeding	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Take blood thinning medication
<input type="checkbox"/> Hepatitis_A_B_C	<input type="checkbox"/> Jaundice	

Diabetes

<input type="checkbox"/> Type 1 Diabetes	<input type="checkbox"/> Type 2 Diabetes	<input type="checkbox"/> Diet (Special/Restricted)
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Breathing/Lungs

<input type="checkbox"/> Snoring *Ask your spouse!*	<input type="checkbox"/> Asthma	<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Hard to breathe through nose	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Seasonal Allergies
<input type="checkbox"/> Wake up tired	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Tuberculosis

Cancer

<input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> Chemotherapy	Cancer Type: _____
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Immune System

<input type="checkbox"/> Lupus	<input type="checkbox"/> Organ Transplant	<input type="checkbox"/> HIV
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> AIDS

Nerves/Muscles/Bones

<input type="checkbox"/> Head Injury	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Thyroid Condition
<input type="checkbox"/> Vertigo	<input type="checkbox"/> Back problems	<input type="checkbox"/> Paresthesia of fingertips (tingling)
<input type="checkbox"/> Tinnitus (ringing in ears)	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Bell's Palsy
<input type="checkbox"/> Trigeminal Neuralgia	<input type="checkbox"/> Ear Congestion	<input type="checkbox"/> Osteoporosis/biphosphonates
<input type="checkbox"/> Artificial Joints: When? _____	Which joint(s)? _____	

Patient Name: _____ :

General Questions

Y/N Do you use tobacco? Type: Cigarettes Cigar Chew How much? _____
Y/N Do you use Cortisone Medication? Reason: _____
Y/N Do you get Cold Sores/Fever Blisters? How often? _____
Do you have any other health problems you feel we need to know about? _____

Women Only:

Y/N Are you pregnant? Due Date: _____
Y/N Are you breastfeeding?
Y/N Are you taking birth control pills?
Y/N Are you on hormone therapy?
Did you know: Periodontal infections can increase the risk of low birth weights in newborns.

Dental Information

Reason for today's visit: _____

Name of Previous Dentist: _____ Phone #: _____

Date of last dental visit: _____ When was your last dental cleaning? _____

Last x-rays? _____

Y/N Have you ever had a serious/difficult problem associated with any previous dental treatment?
If yes, what: _____

Y/N Are any of your teeth sensitive? If yes, to what: Cold Heat Chewing Other _____

Y/N Have you been advised to take antibiotics routinely prior to dental treatment?

Y/N Do you brush your teeth daily? How many times? _____
If you use a manual brush, what type of bristles: Hard Medium Soft
If electric brush, what brand? _____

Y/N Do you floss? How often? _____

Y/N Do your gums bleed?

Y/N Have you ever had gum treatment?

Y/N Have you had braces / orthodontic treatment?

Y/N Do you have any loose teeth?

Y/N Do you know or ever been told you grind your teeth?

Y/N Do you experience jaw joint: clicking popping locking jaw/muscle fatigue?

Y/N Do you have difficulty: swallowing chewing?

Y/N Do you have frequent: headaches any neck, shoulder, or back pain?

Y/N Have you whitened your teeth before? Which system? _____

Comments or concerns?

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature _____

Date _____

OFFICE USE ONLY = OFFICE USE ONLY = OFFICE USE ONLY = OFFICE USE ONLY

Doctor's Signature / Comments: _____

Medical History Update

Date _____ Comments: _____ Signature: _____

Epworth Screening Form

Please answer the following questions:

How likely are you to fall asleep in the following situations?

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

Activity Score (0-3)

Sitting and Reading _____

Watching television _____

Sitting, inactive, in a public place (theater, meeting) _____

As a passenger in a car for an hour with no break _____

Lying down to rest in the afternoon, if circumstances permit _____

Sitting and talking to someone _____

Sitting quietly after lunch without alcohol _____

In a car while stopped for a few minutes in traffic _____

Total Score: _____

A “Handle Me with Care” Partnership

It is very important to communicate all your fears and any issues of apprehension, let’s look at making a “handle me with care” partnership. This short questionnaire will help make a big difference in how your dental treatment is performed and how you feel about going to the dentist.

Put a check mark in the box next to the statement that concerns you or describes your problem.

- I gag easily.
- I feel out of control when I’m lying down in the dental chair.
- I have not been to the dentist for a long time, and I feel uncomfortable about what you will say about my teeth and my dental hygiene.
- Pain relief is a top priority for me.
- I don’t like shots (or have had a bad reaction to shots).
- Please tell me what I need to know about my mouth in order to make an informed decision.
- My teeth are very sensitive.
- Please respect my time. I don’t want to be left sitting in the reception area.
- I want to know costs up front. No money surprises please.
- I have health problems and questions that we need to discuss.