



**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) |
|--|--|--|

**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: _____ |
|--|---------------------------------------|--------------------|

**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:** \_\_\_\_\_

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**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.