Welcome... *Thank you for selecting Sun City Dental!*

PATRICK A. CARR, D.D.S.

Date________________ Home Phone__________________________ Cell Phone____________________________

Patient____
Last Name *First Name* *Initial* *Preferred Name*

Street Address____ City ______________ State__________ Zip__________

Arizona Resident ☐ Y ☐ N Alternate Address____

Sex ☐ M ☐ F Age________ Birthdate__________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Retired ☐ Y ☐ N Social Security #__________________________ Email____

Employed by____ Occupation____

Business Addresss ____ Phone ________________________

Spouse ____ Employer____

In case of emergency, who should we contact?_____________________________________ Phone_____________________

Whom may we thank for referring you?____

PRIMARY INSURANCE

Name of Dental Insurance Company____ Phone________________________

Subscriber Name______________________________ DOB __________ ID or SS# _______________ Group# ____________

Do you have additional insurance? ☐ Y ☐ N ____

Responsible Party_____________________________________ Relationship to Patient _____________________________

MEDICAL HISTORY

Physician's Name____ Date of Last Visit________________

Have you had any serious illnesses or operations? ☐ Y ☐ N If yes, describe _______________________________________

Do you require antibiotics prior to dental treatment? ☐ Y ☐ N If yes, for what _____________________________________

Have you EVER taken any bisphosphonates? (e.g. Fosamax, Actonel, Zometa, Aredia) ☐ Y ☐ N

(Women) Are you pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N

Check (✓) if you have or had any of the following:

☐ AIDS	☐ Cortisone Treatments	☐ Hepatitis Type__________	☐ Rheumatic Fever
☐ Anemia	☐ Cough, Persistent	☐ High Blood Pressure	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough up Blood	☐ HIV Positive	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Diabetes	☐ Jaw Pain	☐ Shingles
☐ Artificial Joints	☐ Epilepsy	☐ Kidney Disease	☐ Stroke
☐ Asthma	☐ Fainting / Dizziness	☐ Liver Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Blood Disease	☐ Headaches	☐ Nervous Problems	☐ Tobacco Habit
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Problems	☐ Psychiatric Care	☐ Tuberculosis
☐ Chemotherapy	Describe_______________	☐ Radiation Treatment	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Respiratory Disease	☐ Venereal Disease

MEDICATIONS

List any medications you are currently taking:

____

____

Pharmacy Name _______________________________

Phone _______________________________________

ALLERGIES

☐ Aspirin
☐ Barbiturates (Sleeping Pills)
☐ Codeine
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Latex
☐ Metal
☐ Other ____________________

DENTAL HISTORY

	YES	NO
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot, cold or sweets?	☐	☐
Have you noticed any mouth odors or bad taste?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you ever experienced any of the following:		
a. Jaw pain or clicking	☐	☐
b. Pain (joint, ear, side of face)	☐	☐
c. Difficulty in opening, closing or chewing	☐	☐

	YES	NO
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you ever had prolonged bleeding following extractions / oral surgery?	☐	☐
Have you had orthodontic treatment?	☐	☐
Have you had periodontal treatment? If yes, when_______________	☐	☐
Do you snore?	☐	☐

Date of last cleaning_______________ Last full-mouth X-rays_______________ Exam_______________

What quality of dentistry do you want us to recommend for you? ☐ Just patch it ☐ Average ☐ The Best

What are your dental motivations/concerns? ☐ Fear ☐ Time ☐ Money ☐ Pain ☐ Wish to save my teeth

Please explain ____

Do you have dentures? ☐ Yes ☐ No ☐ Upper ☐ Lower How old _______________

Do you have a partial? ☐ Yes ☐ No ☐ Upper ☐ Lower How old _______________

Please list any additional comments or concerns you would like us to address:

CONSENT: The undersigned hereby authorizes Dr. Patrick A. Carr to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Dr. Patrick Carr to make a thorough diagnosis of the patient's dental needs.

I also understand that the responsibility for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time service are rendered unless financial arrangements have been made. In the event of default I (we) promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

_______________________________ *Patient / Guardian Signature*

_______________ *Date*