WELCOME TO 6TH SENSE DENTAL!

Patient Information (Confidential)

Name:______________________________ **Preferred** Name:____________________
Birthdate:__________________ Male___ Female___ Social Security #:____________________
Home#: ______________________ Cell#: ____________________________
Work #:______________________ E-Mail:________________________________
Preferred Contact Method: __________________ **Text ok?** Yes or No
Address:____
City_______________________________ State_________ Zip____________________
Single _______ Married _______ Divorced _____ Widowed______
Name of Spouse ______________________________
Are any other family members patients at 6th Sense Dental? Yes ____No ____
How did you hear about us? ____________________________________
Person whom we may call **in case of an emergency**:
_____________________Relationship _____________ Phone __________________

INSURANCE: Leave BLANK if you have no insurance

Name of Insured Person______________________________ Birthdate: ______________
Relationship to patient ___________________ Social Security # ____________________
Name of employer ____
Insurance Company ________________________________ Phone#________________
Group # ______________________ Identification/member # ______________________
Insurance Co. address ____
City______________________ State ______ Zip _____________

I authorize the dentist to release any information including the diagnosis and the records of any treatment rendered to my child or me during the period of such Dental care to third party payers and/or health practitioners. I understand I am responsible for any and all payments at the time of treatment. If 6th Sense Dental seeks enforcement of payment through the services of a collection agency, I shall be responsible for any incidental expenses, including collection costs/attorney fees. I have received a copy of 6th Sense Dental's Notice of Privacy Practices.

Patient (or Guardian) Signature:

______________ ________________________________**Date:**__________

Whom may we release both your medical, dental, PHI & account information to: (Parents, Spouse, Siblings, Dentists, etc.)

Name	Relationship
______________________	______________________
______________________	______________________
______________________	______________________

6TH SENSE MEDICAL HISTORY

Patient Name (PRINT) ____

DOB: ______________________ Age:__________ Weight:__________(lbs) Height:______________

1. Have you been hospitalized or under the care of a **medical doctor** during the past two years? Reason?

____

2. **List medications** taken the past two years:

____

____

3. List **allergy** (i.e., itching, rash, swelling, vomiting) to latex, penicillin, aspirin, or any other medication:

____

4. **CIRCLE** any of the following you have or have had:

Heart Attack/Disease	Inherited Condition/Birth Defect	Rash/Hives/Eczema/Skin Problem
Heart Failure/CHF	Sickle Cell Disease	Glaucoma
Heart Surgery/Stent	Anemia/Blood disorder	Impaired Hearing/Vision/Speech
Angina Pectoris (Chest Pain)	High/Low Blood Pressure	Psychiatric Treatment
Heart Murmur	Transfusion/Receiving Blood Product	Nervous/Anxiety Disorder
Congenital Heart Defect	Diabetes Type 1 / 2	Fainting/Dizzy Spells
Pacemaker	Hyper/Hypoglycemia	Sinus Problems/Infections
Artificial Heart Valve	MRSA (methicillin resistant staph)	Epilepsy/Seizures
Bacterial Endocarditis	Hemophilia	Steroid Therapy
Stroke/Aneurysm	Gastroesophageal Reflux	Current or Previous Tobacco Use
Rheumatic Fever	Stomach Ulcers	Sexually Transmitted Disease
Tuberculosis (TB)	Organ Transplant	AIDS Related/HIV
Sarcoidosis	Artificial Joint	Alcoholism
Emphysema	Tumor	Recreational Drug Use/Addiction
Asthma/Airway Disease	Cancer Type: ______________	Vaping
Hepatitis/Jaundice/Liver Disease	Chemotherapy/Radiation	Medical Marijuana
Thyroid/Pituitary Disease	Arthritis/Scoliosis/Joint Problem	Cankers/Cold Sores/Apthous Ulcer
Cystic Fibrosis	Bladder/Kidney Disease	Eating Disorder/Special Diet
Chronic Obstructive Pulmonary Disorder		Sexual Enhancement Drugs (ie. Viagra)
Blood Thinners	Osteoporosis	Allergies- food, metals, etc.

5. Does your doctor request you take antiobiotic premed prior to dental procedures? YES or NO
6. Do you have any history of taking bisphosphonate medications? YES or NO
7. Ever been victim of **abuse** or neglect (physical, emotional, psychological, sexual)? YES or NO
8. Ever had a reaction to or problem with an **anesthetic**? YES or NO
9. Can you **walk a flight of stairs** without exhaustion or needing a break? YES or NO
10. Any significant medical history not listed above that the **dentist** should be told?

____

11. **Women**: Pregnant? Yes or No? Is there a possibility you are pregnant? Yes or No?
Nursing? Yes or No? Birth Control? Yes or No?

To the best of my knowledge all of the preceding answers are true and correct. I will notify my provider at next visit if there has been any change.

____________________ ____

Date Signature of Patient or Guardian

6TH SENSE DENTAL HISTORY

Print Name ____ Date _____________________________

Reason for today's appointment/primary concern:

____

Most recent dental **exam/cleaning**? ____

Date of last **full mouth set of x-rays**? ____

Was any treatment recommended that was not completed?

____

Please describe any apprehensions about dental treatment or any bad experiences you have had:

____

How can we assure your **comfort** while having dental care?

Local Anesthetic _____ Nitrous Oxide _____ I.V. Sedation ____ Pre-op Oral Sedative______

Headphones _____ Pillow _________ Blanket______ Television _______

Please list any current issues you would like Dr. Rinando to address:

____

How often do you normally visit the dentist? ____

How often do you **brush**? ____

How often do you **floss**? ________only to remove debris ___________times per week

What other aids do you use (electric toothbrush, toothpick, water pick, floss pics etc.)?

____

Have you ever been told you have gum disease, **periodontal disease**? Yes ___ No ___

If yes, what treatment was rendered? ____

Have you ever had **orthodontic** treatment? Yes ____ No ___

Do you wear a retainer? Yes ___ No ___

Have you ever had your teeth bleached or **whitened**? Yes _____ No ______

Satisfied with the **appearance** of your teeth/gums? Yes _____ No _____

If you had a magic wand and could change the appearance of your teeth, what would you do?

____

Do you have any concerns about your **mercury fillings?** Yes ____ No____

Are you ok with the use of **fluoride** in dental products/services? Yes _____ No______

Do you suffer from **snoring or sleep apnea**? Yes _____ No______

Do you wear a **mouth guard or night guard**? Yes _____ No _______

Have you ever **had a traumatic mouth, head, face or neck injury**? Yes ___ No ___

Do you have **headaches**? If so, how often? _________________________

Bite, TMJ, clenching, or grinding problem? Yes___ No____

Any treatment has been done to alleviate the problem? ____

After treatment, my symptoms: ___disappeared ___somewhat relieved ___didn't change much ___got worse