Jason D. West DDS, MS
ADVANCED IMPLANT & PERIODONTAL PROFESSIONALS
Providing Esthetic, Implant and Periodontal Solutions

GUEST INFORMATION (Please Print)

Name: _____ Patient Date of Birth: _____/_____/_____

Referring Dentist/Doctor: _____ Social Security #: _____

Address: _____ City: _____ State: _____ ZipCode: _____

HomePhone: _____ WorkPhone: _____ CellPhone: _____

Email Address: _____

Preferred Contact Method: Home Phone/Cell Phone/Wk Phone/Email Circle One: Minor/Single/Married/Divorced/Widowed

If guest is a student, name of school/college: _____

RESPONSIBLE PARTY (If Not Patient)

Name of person responsible for this account: _____

Relationship to patient: _____

Is there anyone else with whom we may communicate regarding your treatment in our office?

Name: _____ Phone #: _____

Relationship to patient: _____

DENTAL INSURANCE INFORMATION

Subscriber Name: _____ Birthdate: _____/_____/_____

Social Security# or Insurance ID#: _____

Name of Employer: _____ Group#: _____

Insurance Company: _____ Phone#: _____

DENTAL HEALTH HISTORY

Has anyone in your family lost all of their natural teeth? _____

Have you ever had a bad dental experience in a dental office? _____

Are you dissatisfied with the appearance of your natural teeth? _____

Are you aware of grinding or clenching your teeth? _____

PATIENT NAME: _____

MEDICAL HISTORY

Are you aware of any problems with the gums or bone around your teeth? _____

Have you ever had Periodontal Care? YES NO If yes, when? _____

How often do you get your teeth cleaned? _____

Are you allergic or have you had a reaction to:

Y	N	Penicillin/Amoxicillin	Y	N	Latex	Y	N	Tylenol/Acetaminophen
Y	N	Valium or other tranquilizers	Y	N	Sulfites/Sulfa	Y	N	Ibuprofen/Advil
Y	N	Local anesthetic (numbing med)	Y	N	Codeine	Y	N	Aspirin

Please list any other allergies: _____

Please list any medications that you are taking (including OTC, natural, herbal, or homeopathic products):

_____

_____

Are you currently or have you taken any medications for the treatment of Osteoporosis? (ie. Fosamax, Boniva, Actonel, Zometa and Aredia) Y N If yes, how long? _____ How often? _____

Are you in good health? YES NO Are you currently under the care of a physician? YES NO If yes,why?

_____

Do you smoke or use chewing tobacco? YES NO

Do you typically take an antibiotic/pre-medication prior to dental appointments? YES NO

Do you have any heart, lung, liver, or kidney problems? YES NO If yes, please explain:

_____

List any surgeries you have had: _____

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Rheumatic Fever	Y	N	Stroke	Y	N	Cardiac Pacemaker	Y	N
Mitral Valve Prolapse	Y	N	Swollen Ankles	Y	N	High Blood Pressure	Y	N
Heart Murmur	Y	N	Heart Attack	Y	N	Low Blood Pressure	Y	N
Irregular Heart Beat	Y	N	Chest pain/Angina	Y	N	Difficulty Climbing Stairs	Y	N
Fainting Spells	Y	N	Heart Surgery	Y	N	Damaged Heart Valves	Y	N
Blood Transfusion	Y	N	Bruise Easily	Y	N	Jaundice/Liver Disease	Y	N
Thyroid Trouble	Y	N	Hepatitis	Y	N	Are you on Dialysis	Y	N
Kidney Trouble	Y	N	Delay in Healing	Y	N	Diabetes	Y	N
Low Blood Sugar	Y	N	Alcohol Abuse	Y	N	Contagious Diseases	Y	N
Blood Disorder	Y	N	Abnormal Bleeding	Y	N	Stomach Ulcers	Y	N
Anemia	Y	N	Tumor/Growth	Y	N	Radiation/Chemotherapy	Y	N
Snoring/Sleep Apnea	Y	N	Respiratory Problems	Y	N	Bronchitis/Chronic Cough	Y	N
Asthma	Y	N	Convulsions/Epilepsy	Y	N	Hay Fever/Sinus Problems	Y	N
Tuberculosis	Y	N	Emphysema	Y	N	Mental Health Problems	Y	N
Drug Abuse	Y	N	Arthritis	Y	N	Sexually Transmitted Disease	Y	N
Eye Disease/Glaucoma	Y	N	Implants/Artificial Joints	Y	N	Immunosuppressants	Y	N

WOMEN Are you:
Pregnant/trying to get pregnant? YES NO Nursing? YES NO Taking oral contraceptives? YES NO