Wellness BioDentistry

Whole Health Implant Dentistry

Dr. Jordan Baker, DDS

Patient name_____

DENTAL INFORMATION

Please check if you have any of the following problems:

□ Discomfort, clicking, or popping in your jaw

□ Red, swollen or bleeding gums □ Sensitive teeth or gums

□ Blisters or sores in mouth □ Broken/chipped teeth

□ Bad breath □ Locking jaw □ Stained teeth

□ Ringing in ears □ Grinding teeth

□ Injury to your head □ Injury to your face

FUTURE VISITS

Please check any services that you may be interested in:

□ Bleaching □ Sedation Dentistry

□ Clear Braces (Invisalign)

□ Dental Implants □ Cosmetic Dentistry

□ Other (please explain) _____

Name of previous dentist: _____ Last visit:_____

Are you happy with your smile? _____

Have you ever had a serious problem associated with dental work? _____

MEDICAL INFORMATION

Please check if you are taking any of the following:

□ Alcohol □ Tobacco (smoking/chewing) □ Insulin □ Aspirin □ Ibuprofen □ Acetaminophen □ Diuretics

□ Vitamins □ Herbal Supplements □ Recreational Drugs □ Medication for osteoporosis

List all medications and dosages (or you may bring a list with you): _____

Are you currently under the care of a physician or naturopath? _____ What are you being treated for?

Surgeries or hospitalizations: _____

Has your cardiologist or orthopedist recommended antibiotics before dental treatment? □ Yes □ No

Are you pregnant or nursing? □ Yes □ No

Has anyone in your family suffered from the following? (mark all that apply):

□ Heart Disease □ Stroke □ Diabetes □ Cancer

Please check if you have any of the following:

Respiratory

□ Asthma

□ Sinus Problems

□ Tuberculosis

□ Emphysema

□ COPD

□ Sleep Apnea

DENTAL INFORMATION

□ Reflux/Heartburn

□ Ulcers

□ Bulimia or Anorexia

□ Hypoglycemia

□ Celiac

□ Crohn's Disease

Musculoskeletal System

□ Artificial Joint

□Back/Neck Problems

□ Arthritis

□ Rheumatism

□ Osteoporosis

□ Frequent Headaches

□ Migraines

Nervous System

□ Seizures

□ Depression

□ Nervousness

□ Alzheimers

□ Psychiatric Disorder

Circulatory System

□ Anemia

□ Hemophilia

□ Bruise Easily

□ Bleeding Problems

□High Blood Pressure

□ Low Blood Pressure

□ Heart Attack

□ Chest Pain

□ Heart Disease

□ Heart Surgery

□ Artificial Valve

□ Heart Murmur

□ Pacemaker

□ Stent

□ Blood Transfusion

Other

□ HIV/AIDS

□ Hepatitis

Type _____

□ Diabetes

Type _____

□ Stroke

□ Cancer

Type _____

□ Chemotherapy

□ Radiation

□ Malignant Hypothermia

□ Liver Problems

□ Seasonal Allergies

□ Glaucoma

□ Leukemia

Are you allergic to any of the following:

□ Acrylic □ Aspirin

□ Dental Anesthetics □ Codeine

□ Erythromycin □ Food Allergie

□ Jewelry or Metals □ Latex

□ Penicillin/Amoxicillin □ Sulfa Drugs

□ Soaps/Detergents □ Tetracycline

Is there any other medical condition that we need to be aware of?

Patient signature: _____ Date: _____
