GASSER DENTAL
DENTAL IMPLANTS

Gasser Dental Corporation 17220 N. Boswell Blvd Suite 200W
Sun City, AZ 85373
623-972-8217
www.DrGasser.com

Name: _____ Date: _____

Address: _____ SS#: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Sex: M F

Height: ____ feet ____inches Weight _____ lbs.

Emergency Contact: _____ Relationship to Patient: _____
Home Phone: _____ Cell Phone: _____

I. Name of Physician: _____ Phone: _____
Date of last physical exam? _____Reason: _____

II. Have you ever had radiation therapy and/or chemo? _____Yes _____No
If yes, why? _____

III. Dental History:
Date of last dental exam: _____ Date of last dental x-rays_____
Present oral problem: _____
Do you take antibiotics pre-med before dental exams? _____ Yes _____No
What type of pre-med antibiotics do you take? _____
For what reason? _____

IV. Medications: *(Please list any medications you are currently taking:* ☐ *see list attached*

1.	6.	11.
2.	7.	12.
3.	8.	13.
4.	9.	14.
5.	10.	15.

V. Supplements: *(Please list any vitamins, herbs or supplements you are currently taking:* ☐ *see list attached*

1.	6.	11.
2.	7.	12.
3.	8.	13.
4.	9.	14.
5.	10.	15.

VI. How did you hear about Gasser Dental?

___ TV Ad ___ Newspaper, Magazine, Flyer ___ Seminar ___ Doctor/DDS
___ Patient ___ Better Business Bureau ___ Facebook ___ Internet/Website

**** Patient's Initials: _____

ASA 1 2 3 4

✓ Please check "yes" or "no" to the following medical/ health items

YES	/ NO	CARDIOVASCULAR SYSTEM	COMMENTS	
		Heart murmur		
		Pacemaker		
		Defibrillator		
		Heart attack		
		Stroke		
		Rheumatic fever		
		Childhood heart disease		
		Heart disease		
		Stents/artificial valves		
		Vascular grafts/ bypass		
		Aortic stenosis		
		Swollen limbs or painful joints (circle one)		
		High blood pressure		
		Low blood pressure		
		Arteriosclerosis (hardening of the arteries)		
		GASTRO-INTESTINAL S Y S T E M		
		Stomach or intestinal troubles, diarrhea, or vomiting		
		Frequent indigestion or acid reflux		
		Loss of appetite		
		Difficulty swallowing		
		Jaundice or Hepatitis (Type A, B, C) (circle one)		
		Liver trouble		
		Gall bladder issues or stones		
		ENDOCRINE S Y S T E M		
		Gland problem, goiter		
		Thyroid issues		
		Diabetes I or II (circle one)		
		Family members with Diabetes		
		GENITO-URINARY S Y S T E M		
		Kidney disease / dialysis		
		Swollen ankles or eyelids		
		Frequent urination / incontinence (circle one)		
		Venereal diseases / HIV (circle one)		
		RESPIRATORY S Y S T E M		
		Respiratory disease or Tuberculosis		
		Asthma, seasonal allergies (circle one)		
		Tobacco		
		COPD		
		Sleep apnea		
		Cystic Fibrosis		
		Valley fever		

Please continue on next page

*** Patient's Initials: _____

YES	NO		COMMENTS	
		NERVOUS SYSTEM		
		Seizures /Epilepsy		
		Dementia, Alzheimer's, memory loss (circle one)		
		Neuritis, neuralgia or numbness (circle one)		
		Fibromyalgia / Polymyalgia (circle one)		
		Parkinson's disease		
		BLOOD		
		Anemia		
		Blood disease		
		Hemophilia		
		Denied permission to give blood		
		Excessive bleeding following a scratch or cut		
		BONES AND JOINTS		
		Arthritis or rheumatism		
		Osteoporosis		
		Frequent fractures or dislocations		
		Joint replacements: hip, knee or shoulder---Approx. date →		
		HEAD		
		Hearing Impaired		
		Retinal surgery		
		Glaucoma		
		Sinusitis		
		Frequent headaches / Migraines		
		Vertigo		
		TMJ		
		Facial injuries		
		MEDICAL ALLERGIES		
		Reaction to Latex		
		Reaction to Penicillin		
		Reaction to other antibiotics Which one(s) →		
		Reaction to dental anesthetics Which one(s) →		
		Reaction to any drugs or other medicines Which one(s) →		
		Reaction to any metals (i.e. Nickel) Which one(s) →		
		CANCER		
		Have you been diagnosed with cancer? Which type →		
		Did you undergo treatment? Date started →		
		HOSPITALIZATIONS AND SURGERIES		
		Please list below with dates:		
		1. 5.		
		2. 6.		
		3. 7.		
		4. 8.		
		OTHER		
		History of addiction to alcohol		
		History of addiction to drugs		
		History of psychiatric treatment		
		Skin rash, hives, shingles or other skin problems (circle one)		
		Recent gain or loss or weight		
		Do you use any weight loss medications? **Which one(s)** →		
		Past pregnancy or pregnant now		

Please continue on next page

*** Patients Initials_____

PATIENT DENTAL HISTORY

Please mark any questions that you would answer YES"

- ☐ Are you apprehensive about dental treatment?
- ☐ Have you had problems with previous dental treatment?
- ☐ Do you gag easily?
- ☐ Do you wear dentures?
- ☐ Does food catch between your teeth?
- ☐ Do you have difficulty in chewing your food?
- ☐ Do you chew on only one side of your mouth?
- ☐ Do you avoid brushing any part of your mouth because of pain?
- ☐ Do your gums bleed easily?
- ☐ Do your gums bleed when you floss?
- ☐ Do your gums feel swollen or tender?
- ☐ Have you ever noticed slow healing sores in or around your mouth?
- ☐ Are your teeth sensitive?
- ☐ Do you feel twinges of pain when your teeth come in contact with:
  - o Hot foods or liquids?
  - o Cold foods or liquids?
  - o Sour?
  - o Sweets?
- ☐ Do you take fluoride supplements?
- ☐ Are you dissatisfied with the appearance of your teeth?
- ☐ Do you prefer to save your teeth?
- ☐ Do you want complete dental care?
- ☐ How often do you brush?_____ How often do you floss? _____
- ☐ Does your jaw make noise so that it bothers you or others?
- ☐ Do you clench or grind your jaws frequently?
- ☐ Do your jaws ever feel tired?
- ☐ Does your jaw get stuck so that you can't open freely?
- ☐ Does it hurt when you chew or open wide to take a bite?
- ☐ Do you have ear aches or pain in front of the ears?
- ☐ Do you have any jaw symptoms or headaches upon awaking in the morning?
- ☐ Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?
- ☐ Are you unable to open your mouth as far as you want?
- ☐ Are you aware of an uncomfortable bite?
- ☐ Are you a habitual gum-chewer or pipe smoker?
- ☐ Do you sometimes gasp for air during sleep?
- ☐ Do you snore regularly?
- ☐ Do you have any disease, condition, or problem not listed that you feel we should know about? If so, please describe_____

Patient Signature _____ Date _____

Thank you!