GASSER DENTAL CORPORATION
PATIENT MEDICAL HISTORY

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

Email:_______________________________________ Date:_______________
Name: _______________________________________ SSN:_______________
Address: ____
City:________________________________State:__________ Zip: _______________
Phone (Home):_________________________Alternate Number: _______________________
Date of Birth:______________________________Age:___________Sex: M F
How were you referred to this office? ____
Next of Kin:______________________________________Phone: ___________________
Name of Physician:__________________________________Phone: ___________________
Address: ____
Date of last physical exam?________________Reason: _______________________________
Results: ____
Have you ever had radiation therapy? Yes No **IF** yes reason: _______________________
Date last dental x-rays taken:________________ Present oral problem: __________________
Medication(s) you are currently taking: ____
Herbs and/or Supplements you are currently taking: ___________________________________
Do you take antibiotic pre-med before dental work? ___________________________________

Yes	No	Please check appropriate box / circle appropriate answer	Comments	STAFF ONLY
		CARDIOVASCULAR SYSTEM		
		Heart trouble or heart murmur, pacemaker, defibrillator		
		Pain or pressure in your chest, Shortness of breath		
		Rheumatic Fever/Rheumatic heart disease		
		Congestive Heart Disease		
		Swollen or painful joints		Local
		High or Low blood pressure		
		Heart disease from childhood		
		Arteriosclerosis (hardening of the arteries)		
		Stroke or associated problems		
		Artificial Heart Valve or Aortic Stenosis, Vascular Graft		
		GASTRO-INTESTINAL SYSTEM		
		Stomach or intestinal troubles		
		Frequent indigestion, diarrhea, or vomiting problems		
		Loss of appetite or difficulty in swallowing		
		Jaundice or Hepatitis (A, B, C, or other?)		Local
		Liver trouble, gall bladder trouble, or stones		
		ENDOCRINE SYSTEM		
		Gland problem, Goiter, or Thyroid condition		
		Diabetes (sugar or albumin in urine)		A.M.
		Family members with Diabetes or Tuberculosis		

Continued on next page Patients Initials: _______

Yes	No	Please check appropriate box / circle appropriate answer	Comments	STAFF ONLY
		GENITO-URINARY SYSTEM		
		Kidney disease, dialysis, or frequent urination		NSAID
		Swollen ankles or eyelids		
		RESPIRATORY SYSTEM		
		Respiratory Disease or Tuberculosis		
		Asthma, Hay-fever, or Allergies		VENT
		Tobacco, Snuff or alcohol habit		
		NERVOUS SYSTEM		
		Epilepsy or Convulsions		
		Dementia, Alzheimer’s, memory loss, psychiatric treatment		
		Neuritis, Neuralgia or Numbness		
		Parkinson’s Disease		
		BLOOD		
		Dizziness, fainting spells, or anemia		
		Blood disease, Blood transfusion		
		Bleeding gums, denied permission to give blood?		
		Excessive bleeding following a scratch or cut		INR
		BONES AND JOINTS		
		Arthritis, rheumatism, osteoporosis		
		Frequent fractures or dislocations		
		Joint replacements: Hip, Knee or Shoulder		
		SPECIAL ORGANS		
		Eye, Retina surgery, Narrow Angle Glaucoma		N2O
		Sinusitis or Headaches, Ear, Nose or Throat trouble		O.S.
		Facial Injuries, Hearing Impairment		
		OTHERS		
		Tumors, growths, Cysts, or Cancer		
		Recent gain or loss of weight		
		Scarlet Fever, Pneumonia or a High Fever Disease		
		Mumps		
		A reaction to Serums, Drugs, Medicines or Latex		
		Allergy to Penicillin, Antibiotics or Dental Anesthetics		
		Major operations or Hospitalizations, Organ Transplant		
		Pregnancy or Menstrual problems		
		Skin rash, Hives or other skin problems		
		Are you sensitive to any metals (i.e., Nickel) or Latex?		
		Do you use any weight loss medications? Used Phen-fen?		
		Sexually transmitted diseases, Venereal Disease		
		Have you tested HIV positive, or do you have AIDS?		

ASA 1* 2* 3* 4

Patient Signature:____ Date: _______________

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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:
    - Hot foods or liquids?
    - Cold foods or liquids?
    - Sour?
    - 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 below.

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ADVICE AND CONSENT

FINANCIAL RESPONSIBILITY, EXAM AND RELEASE OF INFORMATION

We feel it is in your best interest as our patient to know and understand our financial and dental insurance policies. In addition, certain consents from you are necessary in the ongoing process of providing you dental care.

Financial Responsibility: All fees will be discussed before any treatment is started. Gasser Dental Corporation is a fee-for-service practice. Single visit procedures like fillings, extractions, cleanings, x-rays, denture repairs and relines, root canals, etc., are payable in full at the time the services are rendered. Complex treatment plans require specific financial agreements. If you have dental insurance we will fill out and submit your forms to your insurance provider for them to reimburse you directly. Please note insurance contracts vary greatly and it is your responsibility to know what procedures your plan covers and how much it will pay you for those procedures.

Method for Payment: I hereby agree to pay for services rendered as indicated above and authorize Gasser Dental Corporation to bill and accept payment via bank or credit card. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and fees as may be required to effect collection of this note.

Cell Phone and Email: I consent to the dental practice using my cell phone number to call and text or email me regarding appointments, treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

Consent for Photograph Use: I hereby authorize Gasser Dental Corporation to use before and after photos, models or videos in marketing or educational content presentations.

Consent for Exam: I hereby authorize Dr. Kevin L. Gasser or his designated staff member to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Please be advised that these x-rays, including but not limited to the ICAT Cone Beam Imaging Scan, are for dental evaluation ONLY, and not for the purpose of diagnostics or treatment of medical conditions.

Acknowledgement: Dr. Gasser is an Arizona Licensed General Dentist.

Narcotic Pain Medication Policy: Please be advised that our office will adhere to strict guidelines regarding the usage of narcotic and addictive pain medications like Percocet, Percodan, Vicodin, Lortab, Darvocet, Darvon, etc. We pride ourselves on careful and appropriate pain management techniques that almost always do not require the use of these medications. On those rare occasions when these medications are indicated, we will provide them after an office visit and for only a limited period of time, no more than 5 days. If pain persists, an examination will be required to determine next steps that will not include continuation of the same or similar medication. In addition, we will never provide these medications after office hours or by phone, nor will we provide a refill if the prescription is lost.

Consent to Release Information: I hereby grant Dr. Kevin L. Gasser the right to release my dental and or medical histories and other information about my dental treatment to third party payers (i.e. insurance companies) and or other health professionals.

Dental Records: Your chart legally belongs to the office, but you may request copies in writing at any time. Please indicate whether you want x-rays only or parts of the record. We require at least 72 hours' notice, and there may be a reasonable charge for this service.

Patient Signature: ______________________________ Date: ________________