GASSER DENTAL
DENTAL IMPLANTS

Gasser Dental - 17220 N. Boswell Blvd, 200W
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 bleed at dental appts?_____

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 my 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 my 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

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		
☐	☐	Congenital heart disease		
☐	☐	Prosthetic cardiac valve		
☐	☐	Cardiac valve repair		
☐	☐	Cardiac valve disease		
☐	☐	Cardiac bypass		
☐	☐	Heart transplant		
☐	☐	Infective Endocarditis		
☐	☐	Stents		
☐	☐	Aortic stenosis		
☐	☐	Swollen limbs		
☐	☐	High blood pressure		
☐	☐	Low blood pressure		
☐	☐	Arteriosclerosis (hardening of the arteries)		
☐	☐	Unstable Angina		
☐	☐	Uncontrolled heart failure		
☐	☐	Arrhythmia (irregular heartbeat)		
☐	☐	Do you huff and puff when you climb stairs?		
☐	☐	Do you have trouble running a short distance?		
☐	☐	Do you have trouble doing light housework?		
		GASTRO-INTESTINAL SYSTEM		
☐	☐	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 SYSTEM		
☐	☐	Gland problem, goiter		
☐	☐	Thyroid issues		
☐	☐	Diabetes I or II **(circle one)**		
☐	☐	Family members with Diabetes		

Sign Here --->

YES	NO		COMMENTS	
		GENITO-URINARY SYSTEM		
☐	☐	Kidney disease / dialysis		
☐	☐	Swollen ankles or eyelids		
☐	☐	Frequent urination / incontinence **(circle one)**		
☐	☐	Venereal diseases / HIV **(circle one)**		
		RESPIRATORY SYSTEM		
☐	☐	Respiratory disease or Tuberculosis		
☐	☐	Asthma, seasonal allergies **(circle one)**		
☐	☐	Tobacco		
☐	☐	COPD		
☐	☐	Sleep apnea		
☐	☐	Cystic Fibrosis		
☐	☐	Valley fever		
		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) →		

Sign Here---->

YES	NO	CANCER	COMMENTS	
☐	☐	Have you been diagnosed with cancer? Which type →		
☐	☐	Did you undergo treatment? Date started →		
☐	☐	Do you, or did you have an adrenal gland tumor? Date →		
		HOSPITALIZATIONS AND SURGERIES		
☐	☐	Please list below with dates:		
		1. 5.		
		2. 6.		
		3. 7.		
		4. 8.		
		OTHER		
☐	☐	**Are you currently taking an antibiotic? Which one?** →		
☐	☐	History of addiction to alcohol		
☐	☐	**History of addiction to drugs- Which ones?** →		
☐	☐	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		

ASA 1 2 3 4

Sign Here--->

Please continue to next page

PATIENT DENTAL HISTORY

Pease 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 cannot open freely?
- ☐ Does it hurt when you chew or open wide to take a bite?
- ☐ Do you have earaches 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!