Sleep Snoring and Apnea Center

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13734 First Street / PO Box 337 / Becker, MN 55308

MEDICAL AND DENTAL HISTORY:

Patient Name: _____ _____ _____ _____
Last First MI Preferred Name

Physician/Clinic Name: _____

Are you currently under medical care?
◯ Yes ◯ No

Within the last 5 years, have you been hospitalized for any surgical operation or illness? Please explain:

Have you ever had excessive bleeding requiring special treatment?

Please list all current medications (prescription and non-prescription):

WOMEN ONLY:

Are you pregnant or do you think you may be pregnant?
◯ Yes ◯ No

Are you nursing?
◯ Yes ◯ No

Are you taking birth control pills?
◯ Yes ◯ No

MEDICAL ALERTS:

- ☐ Acid Reflux
- ☐ Aids/HIV Infection
- ☐ Allergies
- ☐ Allergy - Any Metals
- ☐ Allergy Codeine
- ☐ Allergy Iodine
- ☐ Allergy Latex
- ☐ Allergy Novocaine
- ☐ Allergy Pen/Antib.
- ☐ Allergy Sulfa
- ☐ Anemia
- ☐ Anxiety/Nervousness
- ☐ Art. Heart Value
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemo/Radiation
- ☐ Chest Pain
- ☐ Cong. Heart Failure
- ☐ Cong. Heart Problem
- ☐ Controlled Substance
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fainting/Dizzy Spell
- ☐ Gastric Ulcers
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hives or Skin Rash
- ☐ Hypoglycemia
- ☐ Kidney Disease
- ☐ Kidney Trouble
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral V. Prolapse
- ☐ No Epinephrine
- ☐ Pacemaker
- ☐ Premed
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ See Pt Note
- ☐ Shortness of Breath
- ☐ STD
- ☐ Stroke
- ☐ Swelling
- ☐ Thyroid Problem
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Other concerns:_____

DENTAL HISTORY:

Previous Dentist: _____

Last dental visit: _____ Last x-rays taken: _____ How often do you brush? _____ How often do you floss? _____

Do your gums bleed with brushing or flossing?

○ Yes ○ No

Do you have sensitive teeth? (Hot, Cold, Sweets)

○ Yes ○ No

Do you frequently get food caught between your teeth?

○ Yes ○ No

Do you clench or grind teeth?

○ Yes ○ No

Do you wear a guard to protect your teeth at night?

○ Yes ○ No

Have you ever received oral hygiene instructions regarding the care of your teeth and gums?

○ Yes ○ No

Do you have any dental problems at this time?

○ Yes ○ No

Do you have any lumps or sores in or near your mouth?

○ Yes ○ No

Have you had any head, neck or jaw injuries?

○ Yes ○ No

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

○ Yes ○ No

Have you ever experienced any of the following problems in your jaw?

☐ Clicking ☐ Difficulty chewing ☐ Difficulty opening or closing ☐ Pain

AUTHORIZATION AND RELEASE:

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the use of radiographs, study models, photographs, or other diagnostic aids deemed appropriate to obtain a diagnosis. I authorize treatment. I authorize the use of my photographs for educational purposes.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent or guardian: _____ Date: _____

Relationship to patient: _____ Response Date: _____