



801-571-6688

11760 South 700 East, Suite #110, Draper, UT 84020

Draperdentalcare.com

Patient name: \_\_\_\_\_ Male Female  
 Date of birth: \_\_\_\_\_ Social security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Married Single Minor  
 Address: \_\_\_\_\_ Apt #: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Email address: \_\_\_\_\_ Best way to contact you: \_\_\_\_\_  
 Legal guardian name (if patient is under 18): \_\_\_\_\_

Person to contact in case of emergency:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our office?

Friend/Relative (name): \_\_\_\_\_

- |   |   |
|---|---|
| <input type="checkbox"/> Insurance list | <input type="checkbox"/> Sign                         |
| <input type="checkbox"/> Google         | <input type="checkbox"/> Mailer                       |
| <input type="checkbox"/> Facebook       | <input type="checkbox"/> Web                          |
| <input type="checkbox"/> Instagram      | <input type="checkbox"/> Other (please specify) _____ |

What services are you interested in?: (check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Replace silver fillings | <input type="checkbox"/> Invisalign                   |
| <input type="checkbox"/> Having a whiter smile   | <input type="checkbox"/> Replace a missing tooth      |
| <input type="checkbox"/> Smile makeover          | <input type="checkbox"/> Other (please specify) _____ |

**CONSENT TO PROCEED:** I authorize Dr. Chase Judd, DDS, PLLC and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all reasonable medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of standard dental preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

\_\_\_\_\_ I have received a copy, or have been offered and declined a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Signature of patient, legal guardian or authorized agent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



# PATIENT HEALTH INFORMATION

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Current Dental Health: Good / Fair / Poor

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Current Physical Health: Good / Fair / Poor

Under Physician's care in last 12 months? Y / N If Yes, please describe: \_\_\_\_\_

Current Prescription Medications: \_\_\_\_\_

Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint? Y / N

Please indicate if you are currently taking or in the past have taken any of the following:

- Phen-Fen or similar  Tobacco, if yes then frequency: \_\_\_\_\_  
 Fosamax, Boniva, Bisphosphonates  Alcohol: if yes then frequency: \_\_\_\_\_

Have you ever received counseling for use of alcohol or prescription drugs? Y / N

Have you ever had a nervous breakdown or received psychiatric treatment? Y / N

FOR WOMEN ONLY	DENTAL HISTORY
Are you taking birth control pills? Y / N	Previous Dentist: _____
Are you pregnant or trying to get pregnant? Y / N	Last Dental Visit? _____
If Yes, Due Date: _____	Are you currently in pain? Y / N
Are you nursing? Y / N	Do you like your smile? Y / N
	Do you have bleeding or sensitive gums? Y / N

## MEDICAL HISTORY Circle Yes (Y) or No (N) for each item below:

- |                              |                                |                           |                                |
|------------------------------|--------------------------------|---------------------------|--------------------------------|
| Y / N Abnormal Bleeding      | Y / N Congenital Heart Failure | Y / N Hemophilia          | Y / N Rheumatic Fever Positive |
| Y / N AIDS/HIV               | Y / N Dental Anxiety           | Y / N Hepatitis A / B / C | Y / N Seizures                 |
| Y / N Anemia                 | Y / N Diabetes                 | Y / N High Blood Pressure | Y / N Shingles                 |
| Y / N Angina Pectoris        | Y / N Drug Addiction           | Y / N Implant Prosthesis  | Y / N Shortness of Breath      |
| Y / N Arthritis              | Y / N Emphysema                | Y / N Jaundice            | Y / N Sinus Problems           |
| Y / N Artificial Heart Valve | Y / N Epilepsy                 | Y / N Kidney Disease      | Y / N Stroke                   |
| Y / N Artificial Joint       | Y / N Eye Surgery              | Y / N Liver Disease       | Y / N Swollen Ankles           |
| Y / N Asthma                 | Y / N Fainting / Dizzy Spells  | Y / N Mental Disorder     | Y / N Thyroid Disorder         |
| Y / N Blood Transfusion      | Y / N Freq / Severe Headaches  | Y / N Multiple Sclerosis  | Y / N Tuberculosis             |
| Y / N Bruise Easily          | Y / N Frequent Chest Pain      | Y / N Osteoporosis        | Y / N Ulcer                    |
| Y / N Cancer: _____          | Y / N Glaucoma                 | Y / N Pacemaker           | Y / N Unexplained Weight Loss  |
| Y / N Canker Sores           | Y / N Hay Fever                | Y / N Periodontal Disease | Y / N Venereal Disease         |
| Y / N Chemotherapy           | Y / N Heart Disease            | Y / N Radiation Therapy   | Other: _____                   |
| Y / N Cold Sores             | Y / N Heart Murmur             |                           |                                |

## ALLERGIES (Circle all that apply)

- |               |                    |              |              |
|---------------|--------------------|--------------|--------------|
| Acetaminophen | Barbiturates       | Erythromycin | Penicillin   |
| Acrylic       | Codeine            | Latex        | Sulfa        |
| Aspirin       | Dental Anesthetics | Metal        | Other: _____ |

I hereby certify that the answers to the questions above are accurate to the best of my ability. Since a change in medical condition or medication can affect dental treatment, I understand the importance of and agree to take responsibility for notifying the Doctor of any changes at any subsequent appointment.

Patient, Legal Guardian or Authorized Agent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Updated Medical History: Date/ Initial: \_\_\_\_\_ Date/ Initial: \_\_\_\_\_ Date/ Initial: \_\_\_\_\_