SHORTT DENTAL

General Dentistry
12756 10 Mile Road, South Lyon MI
William A. Shortt, DDS, Therese F. Shortt, DDS, Christian J. Shortt, DDS, Juhi S. Shortt, DDS

Please complete **prior** to your appointment on: ______________________________________

Name: ______________________________________ Date: ______________________________________

I have read the above pages and had the opportunity to ask any question to the dentist and am completely satisfied to proceed with the procedure.

By signing below, I am indicating that I agree with the statement above:
Signature of patient _________________________________ Date: __________________________________

Signature of providing dentist: ___________________________ Date: _____________________________
Name of Dentist: ___________________________, D.D.S.

For the following questions, circle YES or NO, whichever applies. Your answers are for our records only and will remain confidential. These facts have a direct bearing on your dental health!

Sex ________ Height ________ Weight ________ Race ________

General Medical History

Are you in good general health? ....YES NO
Has there been any change in your general health in the past year? ....YES NO
My last physical examination was on (approximate date) _______________________________
Are you presently under a physician's care? .... YES NO
If yes, for what condition? ____
Please provide physician's name and address:
____
Have you had any serious illness or operation?.. YES NO
If yes, please list: ____
____
Have you been hospitalized/had a serious illness within the past 5 years?........................YES NO
If yes, please provide the reason: ____

Cardiovascular System

Do you have the following? If yes, please circle

Heart trouble   Heart attack   Coronary insufficiency   Stroke
Damaged heart valve   Congenital heart disease

Rheumatic heart disease, heart murmur?.. YES NO
Chest pain after exertion? .... YES NO
Shortness of breath after mild exercise? .... YES NO
Do your ankles swell? .... YES NO

Do you use extra pillows to sleep? .... YES NO
Do you have a cardiac pacemaker? .... YES NO
Do you have any blood pressure problems? .... YES NO
If yes, check which one: ______ High blood pressure ______ Low blood pressure

Central Nervous System
Do you HAVE or have you EVER had: (please circle)
Epilepsy Fainting spells Seizures Emotional disturbances
Do you follow any treatment for a nervous system disease? ....YES NO

Respiratory System
Do you have a persistent cough or cold? .... YES NO
Do you have or have you ever had tuberculosis? ....YES NO
Is there any history of tuberculosis in your family? ....YES NO
Do you have any sinusitis, sinus trouble? .... YES NO
Do you have emphysema, chronic bronchitis, asthma? .... YES NO

Digestive system
Do you have any stomach ulcers? ....YES NO
Do you have, or have you ever had? (Please circle)
Hepatitis Jaundice Liver Disease
Have you ever vomited blood? .... YES NO
Do you have any diarrhea? .... YES NO

Endocrine System
Do you have diabetes?.. YES NO
Uncontrolled or controlled? (please circle)
Does anyone in your family have diabetes? .... YES NO
Do you urinate more than six times a day? .... YES NO
Are you thirsty very often or do you have a dry mouth? ....YES NO

Hematogenic System
Do you hae anemia, sickle cell disease, blood disorder? .... YES NO
Is there any family history of blood disorders? ....YES NO
Are you hemophilic? .... YES NO
Have you had abnormal bleeding after any surgery, extraction, or trauma? ....YES NO
Have you ever had a blood transfusion? .... YES NO
Immunodeficiency problem? ....YES NO

Allergies
Are you allergic to or have you acted adversely to:
Local anesthetics? ....YES NO
Antibiotics, penicillin, sulfa drug?... YES NO
Barbiturates, sedatives or sleeping pills? ....YES NO
Aspirin? .... YES NO
Iodine? .... YES NO
Codeine or other narcotics? .... YES NO
Latex? ....YES NO

Other allergies? .... YES NO

Please Specify: ____

____

____

Do you have asthma or hay fever? .... YES NO

Do you have or have you ever had hives or skin rash? .... YES NO

Genitourinary System

Do you have or have you ever had:

Kidney trouble? .... YES NO

Syphilis, gonorrhea? .... YES NO

Bones and Joints

Do you have:

Arthritis? .... YES NO

Inflammatory rheumatism? .... YES NO

Bone infection? .... YES NO

Osteoporosis? .... YES NO

Other

Do you have or ever had:

Tumor or malignancy? .... YES NO

Chemotherapy, or Radiation therapy? .... YES NO

Do you have or have you ever had any disease, condition, or problem **NOT** listed above that you think we should know about? .... YES NO

If yes, please explain below:

____

____

____

Are you regularly exposed to x-rays or ANY other ionizing radiation or toxic substances?. YES NO

Are you wearing, or do you wear contact lenses? .... YES NO

Do you drink alcohol? .... YES NO

If yes, how much and how often? ____

Do you smoke tobacco? .... YES NO

If yes How much and how often? ____

Do you use oral tobacco? .... YES NO

If yes How much and how often? ____

Your Medications

Are you taking any of the following medications:

- Antibiotics or sulfa drugs? .... YES NO
- Anticoagulant, blood thinning agents? .... YES NO
- Tranquilizers? .... YES NO
- Iodine? .... YES NO
- Codeine or other narcotics? .... YES NO
- Steroids? .... YES NO

Medication list:

Please provide a list of any type of medication you are currently taking as well as the dosage. Please include prescription AND over the counter medications.

Name/Type of Drug	Dosage	How many times per day?

A little more about your medical history:

Are you pregnant? .... YES NO
Are you nursing? .... YES NO
Do you have any problems associated with your menstrual period? .... YES NO
Are you taking oral contraceptives? .... YES NO
Are you undergoing hormonal therapy? .... YES NO

Dental History

What is your chief dental complaint? ____

____

____

____

Are you experiencing any discomfort or pain at this time? .... YES NO
Are you satisfied with the appearance of your teeth? .... YES NO
Are you able to eat and chew foods satisfactorily? .... YES NO
Do you have headaches, earaches, or neck pain? .... YES NO
Do you frequently experience sinus problems? .... YES NO
Have you had any serious trouble associated with any previous dental treatment? .... YES NO

If yes, please explain: ____

____

Other conditions not listed: ____

____

Patient dental evaluation

Please rank the following in order, which might prevent you from having dental treatment:

_____ Fee for treatment _____ Fear of pain _____ Length of treatment

_____ Expected result _____ No concerns

About your natural teeth

Length of time without natural teeth: Upper arch __________ Lower arch __________

Previous denture type (please check all that apply):

_____ Full denture _____ Partial denture _____ Metal base _____ Over-denture

About your dentures/Partials

How old are your present dentures/partials? ____

How many sets of dentures/partials have you had? ____

Are you wearing your most current set of dentures/partials right now? .... YES NO

Are you able to eat strawberries, apples, nuts, steak, corn on the cob? .... YES NO

Are you satisfied with your denture(s)/partial(s) (please check)?

_____ Yes, in most ways

_____ Yes, but they have some faults

_____ No, but I wear them most of the time

_____ No, I seldom if ever wear them

Are you satisfied with the appearance of your denture(s)/partial(s) (please check)?

_____ Yes, they have a pleasant/natural appearance

_____ Yes, but I would like to change some things

_____ No, they are not natural, but I wear them

_____ No, they do not look real or are unsightly

Does your upper denture/partial stay in place?

_____ Yes, it stays in place most of the time

_____ No, it moves so much I do not wear it

_____ No, it often comes loose while eating or talking

_____ No, it needs to be secured with distasteful adhesives

Does your lower denture/partial stay in place?

_____ Yes, it stays in place most of the time

_____ No, it moves so much I do not wear it

_____ No, it often comes loose while eating or talking

_____ No, it needs to be secured with distasteful adhesives

Your ability to eat the foods you desire:

_____ Yes, I am able to chew most foods

_____ Yes, but I avoid certain foods, or cook foods so they are softer

_____ No, I avoid many foods I would like to have

_____ No, I am able to chew better with them out

How do your dentures affect your ability to speak?

_____ Yes, I have little or no difficulty speaking

_____ Yes, but they do cause some problems

_____ No, speaking is always difficult

_____ No, it is very difficult

The comfort of your upper denture/partial?

_____ Yes, it causes me no discomfort
_____ Yes, but it does occasionally cause some discomfort
_____ No, I seldom or never wear it
_____ No, it causes numerous sore sports

The comfort of your lower denture/partial?

_____ Yes, it causes me no discomfort
_____ Yes, but it does occasionally cause some discomfort
_____ No, I seldom or never wear it
_____ No, it causes numerous sore sports

Have you been advised by a physician to have your missing teeth replaced? .... YES NO

If yes, please explain: ____

____

As a result of losing your tooth/teeth, do you suffer from any of the following?

_____ Headache	Always ( )	Occasionally ( )
_____ Teeth grinding/clench	Always ( )	Occasionally ( )
_____ Gagging reflex	Always ( )	Occasionally ( )
_____ Difficulty swallowing	Always ( )	Occasionally ( )
_____ Mouth sores	Always ( )	Occasionally ( )
_____ Difficulty chewing food	Always ( )	Occasionally ( )
_____ Dizziness, ringing in ears	Always ( )	Occasionally ( )
_____ Numbness in lower lip	Always ( )	Occasionally ( )
_____ Difficulty speaking	Always ( )	Occasionally ( )
_____ Digestive disorders	Always ( )	Occasionally ( )
_____ Nutritional Disorders	Always ( )	Occasionally ( )

Do you suffer from any of the following problems?

_____ Avoid eating in public
_____ Avoid being seen in public
_____ Depressed or insecure about the loss of teeth
_____ Difficulty adjusting to life without your teeth?

Please tell us why you want an implant?

____

____

____

____

General dental responsibility and consent statement:

I hereby authorize and request the performance of: ______________________________

____

____

***** You must return to our office at regular intervals for examination and service to maintain the implant as you would your normal teeth. If you do not do this, difficulties may arise, resulting in the loss of the implant(s). Smoking and/or excessive alcohol consumption is a deterrent to a successful implant and may set your implant up for failure. Under such circumstances, the responsibility would be yours should the implant fail or should it need additional procedures**.
______ (please initial here)

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or their supervised staff for diagnostic purposes and/or dental treatment. These records may include study models, photographs, radiographs (x-rays), and blood studies. I understand and acknowledge that I am financially responsible for the services provided for myself, regardless of insurance coverage. Treatment plans involving extended credit circumstances are subject to a credit check. I also understand that the treatment estimate presented to me is only an estimate. Occasionally, the need may arise to modify the treatment. In such a case, I will be informed of the need for additional treatment, and any fee modification.

By signing below, I agree to the above statement AND agree to the best of my knowledge, the information I have provided in this form is accurate.

____
Signature of patient/guardian Date

____
Signature of witness Date

____
Signature of doctor Date