Aranda & Aranda, DDS - 9/6/2022

Patient Information

Contact

Please fill out the information below

Preferred Name	Address	City	State
Zip	Gender	Primary Phone	Other Phone
Date of Birth		Email	

Other

How did you hear about our office?
Reason for consultation?
Date of last cleaning

Insurance Information

Guardian

Guardian First Name	Guardian Last Name	Address	City
State	Zip	Mobile Phone	Work Phone
Date of Birth		Email	

Insurance (if applicable)

Company	Phone	Subscriber/Member ID

Medical Information

Sleep/Airway Issues

Does the patient tend to be a mouthbreather?	Does the patient snore at night?	Does the patient seem rested in the morning?	Is the patient often sleepy during the day?
Has the patient seen an ear, nose or throat specialist?	Is the patient using a sleep apnea device?		

Medical History

Acid Reflux	ADHD/ADD	AIDS/HIV	Anemia
Arthritis	Asthma	Autism	Bone Disorders
Cancer	Cerebral Palsy	Chest Pain	Chronic Neck Pain
Cold Sores/Herpes	Diabetes	Down Syndrome	Endocrine Problems
Emotional Disorders	Epilepsy	Headaches	Heart Condition
Hepatitis	Ear Pain	Immune Problems	Kidney Problems
Low Blood Pressure	Muscular Disorders	Nervous Disorders	Organ Transplant
Osteoporosis	Prolonged Bleeding	Rheumatic Fever	Scoliosis
Seizures	Sinus Problems	Tuberculosis	

Dental History

Clicking of Jaw	Jaw Pain	Painful Chewing	Periodontal Problems
TMJ Problems	Do your gums bleed when you brush?	Is the patient seeing any other dental specialists?	Any dental restorations needing to be completed?
Have there ever been any injuries to the face, mouth or chin?	Have you ever lost or chipped any teeth?	Do you have any pain or soreness around your face, neck or back?	Is any part of your mouth sensitive to temperature or pressure?

Is the patient currently pregnant?	Have adenoids been removed?	Have tonsils been removed?	Currently taking any medications?
Are antibiotics necessary prior to treatment?	Allergies?	Any diseases or problems not mentioned above?	