Dr. Jennifer Spera, DDS
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www.SperaDental.com

Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. Date ______

Last Name ______ First ______ MI ______

Preferred Name ______ Birth Date ______ Social Security ______

Address ______

City ______ State ______ Zip ______

Home Tel. ______ Cell ______ Work ______

Email ______

Preferred Method of Contact: (check all that apply) ☐ Home phone ☐ Cell ☐ Work ☐ Text ☐ Email ☐ Other ______

In Case of Emergency, please contact ______ Phone ______ Relation ______

Referred By ______

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time the services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collection to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid for by an insurance company.

I understand that any free estimate listed for dental care can only be extended for a period of six months from the date of patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended, and that interest will be charged to and paid for by me on any billed balance outstanding for more than 60 days, at a rate of one and one-half percent (1.5%) per month. I further agree that the reasonable value of said services shall be billed unless objected to , by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

Cancellations less than 48 hours of scheduled appointment will result in a $65.00 cancellation fee ______
Initials

______
Signature of patient, parent, or guardian ______ Date

______
Signature Update ______ Date

______
Signature Update ______ Date

MEDICAL HISTORY

Patient Name ______________________ Nickname ______________ Age ________

Name of Physician/and their specialty ______________________________

Most recent physical examination ______________________ Purpose ______________________

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury ______	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, ________)		
☐ latex		
☐ nuts ______		
☐ fruit - ______		
☐ other ______		
3. heart problems, or cardiac stent within the last six months ___	☐	☐
4. history of infective endocarditis ______	☐	☐
5. artificial heart valve, repaired heart defect (PFO) ______	☐	☐
6. pacemaker or implantable defibrillator ______	☐	☐
7. orthopedic implant (joint replacement) ______	☐	☐
8. rheumatic or scarlet fever ______	☐	☐
9. high or low blood pressure ______	☐	☐
10. a stroke (taking blood thinners) ______	☐	☐
11. anemia or other blood disorder ______	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) ______	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis ___	☐	☐
14. tuberculosis, measles, chicken pox ______	☐	☐
15. asthma ______	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _	☐	☐
17. kidney disease ______	☐	☐
18. liver disease ______	☐	☐
19. jaundice ______	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency ______	☐	☐
21. hormone deficiency ______	☐	☐
22. high cholesterol or taking statin drugs ______	☐	☐
23. diabetes (HbA1c = ______) ______	☐	☐
24. stomach or duodenal ulcer ______	☐	☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) ______	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___	☐	☐
27. arthritis ______	☐	☐
28. autoimmune disease ______ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma ______	☐	☐
30. contact lenses ______	☐	☐
31. head or neck injuries ______	☐	☐
32. epilepsy, convulsions (seizures) ______	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) ______	☐	☐
34. viral infections and cold sores ______	☐	☐
35. any lumps or swelling in the mouth ______	☐	☐
36. hives, skin rash, hay fever ______	☐	☐
37. STI/STD/HPV ______	☐	☐
38. hepatitis (type ___) ______	☐	☐
39. HIV/AIDS ______	☐	☐
40. tumor, abnormal growth ______	☐	☐
41. radiation therapy ______	☐	☐
42. chemotherapy, immunosuppressive medication ______	☐	☐
43. emotional difficulties ______	☐	☐
44. psychiatric treatment ______	☐	☐
45. antidepressant medication ______	☐	☐
46. alcohol/recreational drug use ______	☐	☐
ARE YOU:		
47. presently being treated for any other illness ______	☐	☐
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) ______	☐	☐
49. taking medication for weight management ______	☐	☐
50. taking dietary supplements ______	☐	☐
51. often exhausted or fatigued ______	☐	☐
52. experiencing frequent headaches ______	☐	☐
53. a smoker, smoked previously or use smokeless tobacco ___	☐	☐
54. considered a touchy/sensitive person ______	☐	☐
55. often unhappy or depressed ______	☐	☐
56. taking birth control pills ______	☐	☐
57. currently pregnant ______	☐	☐
58. diagnosed with a prostate disorder ______	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________ Date ________

Doctor's Signature ______________________ Date ________

Initials/Date each year :

Updated: Updated: Updated: **ASA ______ (1-6)**

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DENTAL HISTORY

Name ______________________________ Nickname ___________________________ Age ___________
Referred by _________________________ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist ____________________________ How long have you been a patient? ______________ Months/Years
Date of most recent dental exam _____ /_____ /_____ Date of most recent x-rays ______ /______ / ______
Date of most recent treatment (other than a cleaning) _____ / _____ / _____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___] ______ ☐ ☐
2. Have you had an unfavorable dental experience? ______ ☐ ☐
3. Have you ever had complications from past dental treatment? ______ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ______ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? ______ ☐ ☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? ______ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? ______ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ______ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? ______ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? ______ ☐ ☐
11. Have you ever experienced gum recession? ______ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ______ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? ______ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? ______ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ______ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ______ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? ______ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? ______ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ______ ☐ ☐
20. Do you frequently get food caught between any teeth? ______ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ______ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? ______ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ______ ☐ ☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? ______ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? ______ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? ______ ☐ ☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? ______ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? ______ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ______ ☐ ☐
30. Do you clench or grind your teeth together in the daytime or make them sore? ______ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? ______ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? ______ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? ______ ☐ ☐
34. Have you ever whitened (bleached) your teeth? ______ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? ______ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? ______ ☐ ☐

Patient's Signature ____________________________________ Date ____________
Doctor's Signature ____________________________________ Date ____________

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