ANGELA B. BATESON, DDS

www.batesondds.com BatesonDentistry@gmail.com GENERAL DENTISTRY 1400 S. Main Street, Findlay, Ohio 45850 419-425-0303

FC	OR OFFICE USE ONLY
	In computer
	NP letter
	Thank you referral letter
	Scanned

<u>P</u>	AIIE	NI II	NFORMATION				
Patient Name				Date			
LAST, FIRST	-		MI (PREFERRED NAME)				
Birth date Gender: □	Male	□Fema	ale Family Status:	□Married □Single □	□Divorced	□Wi	dow
Social Security #		E-n	nail address				
Address							I
STREET			Al	PARTMENT #			
Home Phone Work	/Ext			Cell			
May we leave a treatment message? □Yes □No	W	/hat typ	e of message may we leav	e? □Voice message	☐Text mes	sage	
Where may we leave treatment messages? □Home	phone	□Cell	phone □Work phone				
Preferred method to notify you of your appointments		Home	☐ Work ☐ Cell	☐ E-Mail ☐ Text N	Message		
Preferred appointment times ☐ Morning ☐ Afternoo	n 🖵 E	vening	☐ Any Time Preferred a	ppt. days □M □ T		Γh	□F
Employer Name			Occupation	າ			
Address							
STREET Fmergency contact:				ITY STATE ZIP			
Emergency contact:NAME / RE	LATIONS	HIP		PHONE			
	MED	ICAI	_ HISTORY				
		ICAL	<u> </u>				
(Check DK if you don't know the answer to the question)							
DO YOU WEAR CONTACT LENSES? JOINT REPLACEMENT. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? (please circle)	YES NO		Do you use controlled substanc Do you use tobacco (smoking, s If so, how interested are you i	snuff, chew, bidis)?	YES		DK
If yes, have you had any complications?			(circle one) VERY / SOMEV Do you drink alcoholic beverage	VHAT / NOT INTERESTED	П		П
Are you scheduled to begin taking either of the medications alendronate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease?			If yes how much alcohol did you If yes, how much do you typical	drink in the last 24 hours?—			
Since 2001, were you treated, or presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®)			WOMEN ONLY. Are you: Pregnant? If yes, number of we	noke			
for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?			Taking birth control pills or horm Are you nursing?	nonal replacement?	-		
ALL FROITS. Places shock and list readings for any allegation up a	a., ba.,a.						
ALLERGIES. Please check and list reactions for any allergies you may	YES NO				YES	S NO	DK
Local anesthetics Aspirin			Metals Latex (rubber)				
Penicillin or other antibiotics			lodine				
Barbiturates, sedatives, or sleeping pills Sulfa drugs			Hay fever/seasonal Animals				
Codeine or other narcotics			Food				
Other:			Other				
Have you ever had any of the following?							
Please check those that apply:	YES NO		0		YES		DK
Artificial (prosthetic) heart valve Previous infective endocarditis			Congenital heart disease (CHD) Unrepaired, cyanotic CHD	1			
Damaged valves in transplanted heart			Repaired (completely) in last 6 Repaired CHD with residual de	fects			
Except for the conditions listed above	antibioti	c prophy	laxis is no longer recommende	d for any other form of CHD).		

Anthris	Please check any of the following that may apply to you:									
Affords	Aksarmal blanding					outho/tumors				DK
Andreis										
Althris Recurrent infections. If yes, indicate type							r liver disease			
Authorimum. Grading disease Grading disease					l Rec	current infections.				_
Autoimme Blood transfacion (if yes, date:	Asthma				1 Kidr	Iney disease				
Cancer/chemotherapy/Radiation Treatment Neurological disorders. If yes, specify					1 Mer	ental health disord	ers. If yes, specify			
Cardiovescular disease. If jays, specify below. Angina Persistent svoillen glands in neck	Blood transfusion. If yes, date:				1 Mal	Inutrition				
Affordioelosis Help Mode pressure Recurrent incident. If yes, specify below							ers. If yes, specify			
Artificial heart valves		u		L						
Additional heart valves										
Congested heart failure										
Connay after y disease Pacemaker Rheumatic heart Severe headaches/migraines					1100					
Concept part y disease Rehumatic heart Severe headacheshingraines Damaged heart valves Gisease/Rheumatic fever Severe rapid weight loss Damaged heart valves Gisease/Rheumatic fever Severe or rapid weight loss Damaged heart valves Gisease/Rheumatic fever Severe or rapid weight loss Damaged heart valves Damaged heart					Rhe					
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Hear ditack Sexually transmitted diseases										
Chest pain upone exertion	Heart attack									
Chronic pain Glabeles Type (Insulin dependent), or Type II Glabeles Type (Insulin dependent), or Type (Insulin dependent), or Type (Insulin dependent), or Type (Insulin										_
Diabetes Type I (insulin dependent), or Type II	Chronic pain				3 Slee	ep disorder				
Ealing disorder. If yes, specify	Diabetes Type I (insulin dependent), or Type II				S Sor	res or ulcers in the	e mouth			
Eplepsia Cases the bedding Case Reflux (Aperistent hearburn Rese explain Please	Eating disorder. If yes, specify:				3 Stro	oke				
Excessive bleeding	Epilepsy						nematosus			
Fainting spells or seizures GReflux / persistent hearthum GReaucoma Do you have any disease not listed that I should know about? Please explain Please explain Please explain Please explain Please explain Name of physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Pyes No If yes, please list Name of physician or deries who made the recommendation Phore number Name of physician or deries who made the recommendation Phore number DENTAL HISTORY Are you missing any leeth other than wisdom teeth or orthodontic extractions?	Excessive bleeding				1 Tub	berculosis				
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Do you have any disease not listed that I should know about? Please explain	GE Reflux /persistent heartburn				1 Ulce	ers				
Please list all prescribed and over-the-counter medications you take: Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? I'ves No										
DENTAL HISTORY Are you having dental discomfort today? Are you missing any teeth other than wisdom teeth or orthodontic extractions? Are you missing any teeth other than wisdom teeth or orthodontic extractions? Are you missing teeth been replaced? Do your guns bleed when you brush or floss? Are you concerned about gun disease? Do you have any concerns about the appearance of your teeth? Do you clench or grind your teeth? Boy ou clench or grind your teeth? How would you describe your dental health? Excellent Good Fair Poor Have you ever had a problem with: Local anesthetic?				or to	o your dental trea	atment? □Yes	□No			
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Are you having dental discomfort today? Are you missing any teeth other than wisdom teeth or orthodontic extractions? Are you gums bleed when you brush or floss? Do your gums bleed when you brush or floss? Do you gums bleed when you brush or floss? Do you have any concerns about gum disease? Do you have any concerns about the appearance of your teeth? Does it hurt to bite or chew? Do you clent or grind your teeth? How would you describe your dental health? Excellent Good Fair Poor Have you ever had a problem with: Local anesthetic? Previous dental treatment? Nitrous oxide sedation? Do you want to become a regular continuing care patient in our practice? Do you want to become a regular continuing care patient in our practice? Do you take antibiotics for dental appointments? IYes No If yes, what antibiotic do you take? When was your last cleaning or periodontal therapy? What factors are most important for your satisfaction with our office? CONSENT FOR TREATMENT NOTE: BOTH Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/he	If yes, please list					eatment? □Yes	Phone number			
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NOTE: BOTH Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her.	Name of physician or dentist who made in Name of primary care physician. Name of primary care physician. Are you having dental discomfort today? Are you missing any teeth other than wisdom teeth or orthodontic ext. Have missing teeth been replaced? Do your gums bleed when you brush or floss? Are you concerned about gum disease? Do you have any concerns about the appearance of your teeth? Does it hurt to bite or chew? Do you clench or grind your teeth? How would you describe your dental health? □Excellent □Goode Have you ever had a problem with: Local anesthetic? Previous dental treatment? Nitrous oxide sedation? Cleaning or periodontal therapy? Do you want to become a regular continuing care patient in our praction or possible problems. □Yes □No. When was your last cleaning or periodontal therapy? What factors are most important for your satisfaction with our office?	the reco	Commercial	L I	HISTORY	Y YES	Phone number Phone number NO			
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Date

Signature of Patient / Legal Guardian