

BAST DENTAL CLINIC
JOHN P. BAST DDS
570 UNIVERSITY AVENUE FAIRBANKS, AK (907) 479-2206

Welcome to our office! Please take a moment to complete this form as thoroughly as possible. This information will help up to address your dental needs, concerns, and desires. DATE _____

NAME: _____ **DOB:** _____ **SSN:** _____

ADDRESS'S: PHYSICAL: _____

MAILING: _____

EMAIL: _____

PHONE NUMBERS: HOME: _____ **CELL:** _____ **WORK:** _____

PREFERRED METHOD OF CONTACT: Home Phone Work Phone Cell Phone: Call/Text Email

EMERGENCY CONTACT: NAME: _____ **NUMBER:** _____ **RELATIONSHIP :** _____

PREVIOUS DENTIST: _____ **LAST EXAM AND CLEANING:** _____

Whom may we thank for referring you? _____

OCCUPATION: _____ **EMPLOYER:** _____

SPOUSE NAME: _____ **SPOUSE EMPLOYER:** _____

INSURANCE COMPANY: _____

SUSCRIBERS NAME: _____

SSN: _____ **GROUP NO:** _____ **Member NO:** _____

SECONDARY INSURANCE COMPANY: _____

SUSCRIBERS NAME: _____

SSN: _____ **GROUP NO:** _____ **Member NO:** _____

PLEASE CHECK ANY FOLLOWING CONCERNS:

Teeth

- Missing
- Loose
- Wisdom
- Food impaction
- Crooked
- Crowding
- Decay
- Wear/ abrasion
- Fractures
- Broken fillings
- Broken teeth

Tooth Sensitivity

- Hot
- Cold
- Sweet
- Biting

Gums/Mouth

- Recession
- Pockets
- Bleeding
- Bad Breath
- Dry mouth

TMJ/Jaw

- Grinding
- Clenching
- Jaw pain
- Joint pop/click
- Difficulty opening/ chewing

Dissatisfied Dental

- Denture
- Root canal
- Restoration
- Crowns
- Bridges

PLEASE CHECK ANY FOLLOWING INTEREST:

- Athletic guards
- Dental Implants
- Dentures
- Electric toothbrush
- Improved Esthetes

- Laminates/Veneers
- Nitrous/ Sedation
- Night-guards
- Straighter teeth
- Sealants

- Snoring Cessation
- Tooth colored fillings
- Tobacco Cessation
- Tooth Desensitization
- Whitening treatment

HEALTH HISTORY

PHYSICIANS NAME: _____ PHARMACY: _____

Please indicate if you have ever experienced any of the following

- AIDS/HIV
- Allergies
- Arthritis / Gout
- Artificial Joints - _____
- Auto Immune disease
- Rheumatism /Osteoarthritis
- Sjogrens Syndrome
- Fibromyalgia / Chronic Fatigue
- Lupus
- Chrohn's disease
- Multiple sclerosis
- _____
- Back / Neck Problems
- Blood Disease
- Anemia
- Abnormal bleeding
- Hemophilia
- Cancer / Chemo / Radiation Therapy
- Chemical Dependency
- Cortisone Steroid Treatments
- Diabetes - Type 1 / Type 2
- Diet Medications / Eating disorders
- Dry mouth - Chronic / Occasional
- Headache/Migraines/Severe/Frequent
- Hearing Impaired
- Heart Problems Current / Past
 - Artificial Heart Valves
 - Congenital Heart Conditions
 - Cardiovascular disease
 - High Blood Pressure
 - History of Endocarditis
 - Heart Attack Date _____
 - Heart Surgery _____
- Pacemaker or Defibrillator
- Hepatitis Type A / B / C
- Herpes / Cold Sores / fever blisters
- Kidney Disease
- Liver Disease
- Neurologic Problems
 - Epilepsy / Seizures
 - Fainting or Dizziness
 - Cerebral Palsy
 - Alzheimer disease
 - Parkinson disease
- Osteoporosis / Osteopenia
- Bone density treatment
- Organ Transplant _____
- Psychiatric Care / Anxiety / Depression
- Respiratory Problems
 - Emphysema
 - Cough, persistent or bloody
 - Asthma: Chronic / Exercise induced
 - Shortness of breath
 - COPD
- Sleep Apnea / Snoring / CPAP machine
- Stomach/ Intestinal disease
 - Colitis
 - Gastric Reflux GERD
 - Gastric Bypass Surgery
 - Heartburn
 - Ulcers
- Stroke
- Thyroid Problems
- Tobacco Habit / Smoking / Chew/ E-Cig
- Tumor or growths of Head / Neck

List any other Medical conditions that you are currently being treated for? _____

WOMEN ONLY Are you Pregnant Yes/ No Due Date: _____

ANY KNOWN ALLERGIES OR ADVERSE REACTIONS:

- | | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Barbiturates/ Sedatives | <input type="checkbox"/> Dental Anesthetic |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin or any other antibiotic |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Sulfa |
- Other: _____

List all **MEDICATIONS** you are taking including **Vitamins** or **herbal supplements**:

Signature: _____ Date: _____