SUN VALLEY
DENTAL GROUP
BRIAN GALBRAITH, D.D.S

Welcome!

Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you. Thank You!

PATIENT INFORMATION

Name________________ Soc. Sec. # ________________

How Do you prefer to be addressed? ________________

Email________________ Cell Phone________________

Address________________ Home Phone ________________

City________________ State________________ Zip Code________________

Sex M ☐ F ☐ Age________ Birthdate____________ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Patient Employed By________________ Occupation________________

Business Address ________________ Business Phone ________________

Whom May We Thank For Referring You? ________________ Business Phone________________

Previous Dentist________________

Person to Notify in case of Emergency ________________ Phone ________________

PRIMARY INSURANCE

Person Responsible for Account________________

Relation to Patient____________ Soc. Sec. #____________ Birthdate____________

Address ________________ Phone________________

City________________ State________________ Zip Code________________

Person Responsible Employed By________________ Occupation ________________

Business Address________________ Business Phone ________________

Insurance Company ________________

Address ________________ Phone ________________

Plan #________________ Group # ________________

Name of Other Dependents Under This Plan ________________

MEDICAL HISTORY

Do you have a personal physician? ________________ Physician's Name________________

Phone #________________ Date of last visit ________________

Are you currently under the care of a physician? ________ Please Explain ________________

Your current physical health is ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription or over the counter herbal supplements?

____

Have you ever had any serious head or neck injury? ☐ Yes ☐ No

Have you taken Fosamax, Actonel, Boniva or any other bisphospanates? ☐ Yes ☐ No

Do you take, or have you taken Phen-Fen or Redux? ☐ Yes ☐ No

FOR WOMEN: are you using a prescribed method of birth control ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you Nursing? ☐ Yes ☐ No

Are you on a special Diet? ☐ Yes ☐ No

If yes please explain________________

Y N AIDS/ HIV POSITIVE	Y N Cortisone Medicine	Y N Hospitalized for any Reason	Y N Radiation Treatments
Y N Alzheimer's Disease	Y N Diabetes	Y N Hemophilia	Y N Recent Weight Loss
Y N Anaphylaxis	Y N Drug Addiction	Y N Hepatitis A	Y N Renal Dialysis
Y N Anemia	Y N Easily Winded	Y N Hepatitis B or C	Y N Rheumatic Fever
Y N Angina	Y N Emphysema	Y N Herpes	Y N Rheumatisim
Y N Arthritis/ Gout	Y N Epilepsy or Seizures	Y N High Blood Pressure	Y N Scarlet Fever
Y N Artificial Heart Valve	Y N Excessive Bleeding	Y N High Cholesterol	Y N Shingles
Y N Artificial Joint	Y N Excessive Thirst	Y N Hives or Rash	Y N Sickle Cell Disease
Y N Asthma	Y N fainting spells/ Dizziness	Y N Hypoglycemia	Y N Sinus Trouble
Y N Blood Disease	Y N Frequent Cough	Y N Irregular Heartbeat	Y N Spina Bifida
Y N Blood Transfusion	Y N Frequent Diarrhea	Y N Kidney Problems	Y N Stomach Disease
Y N Breathing Problems	Y N Frequent Headaches	Y N Leukemia	Y N Stroke
Y N Bruise Easily	Y N Genital Herpes	Y N Liver Disease	Y N Swelling of Limbs
Y N Cancer	Y N Glaucoma	Y N Low Blood Pressure	Y N Thyroid Disease
Y N Chemotherapy	Y N Hay Fever	Y N Lung Disease	Y N Tonsillitis
Y N Chest Pains	Y N Heart Attack/Failure	Y N Mitral Valve Prolapse	Y N Tuberculosis
Y N Cold Sores / Fever Blisters	Y N Heart Murmur	Y N Osteoporosis	Y N Tumors or Growths
Y N Congenital Heart Disorder	Y N Parathyroid Disease	Y N Pain in Jaw/Joints	Y N Convulsions
Y N Heart Trouble	Y N Psychiatric Care	Y N Ulcers	Y N Yellow Jaundice
Y N Pace Maker			

Have you ever had any serious illness not listed? ☐ Yes ☐ No If yes ______________________________

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Erthromycin

Other ______________________________

Do you use Controlled Substances? ☐ Yes ☐ No IF Yes ______________________________

DENTAL HISTORY

Immediate Dental Concerns ______________________________

2. Do your gums bleed when you brush? ______________

3. How often do you brush your teeth? ______________

4. Do your gums ever feel swollen & tender? ______________

5. Do sweets, hot or cold cause pain in your mouth? ______________

6. Have you ever had periodontal disease? ______________

7. Do you have popping / pain in your jaw? ______________

8. Does food catch between your teeth? ______________

9. Do you have any swelling or lumps in your mouth? ______________

10. Do you grind your teeth at night? ______________

11. Do you currently have any pain in your mouth? ______________

12. Are you satisfied with the appearance, shape and color of your teeth? ______________

Do you wish to have fluoride treatment? Yes ________ NO ________

SMILE HISTORY

Do you smile with confidence? ☐ Yes ☐ No

Have you ever worn braces or Invisalign ☐ Yes ☐ No

Have you ever tried teeth whitening? ☐ Yes ☐ No

Have you ever had a professional smile consultation? ☐ Yes ☐ No

I have Received HIPPA Information ____________ **Signature** ______________________ **Date**____________

WE ARE GLAD YOU ARE HERE! WE'LL TAKE GOOD CARE OF YOU!