LAKEWOOD
COMPLETE DENTISTRY

Dr. Vincenzo Artino
7575 W. 20th Avenue
Lakewood, CO 80214
Tel: (303)238-2800

WELCOME!

Patient Information

Name: _____ Nickname: _____

Male / Female /Prefer not to say

Pronouns: _____

Address: _____City: _____Zip Code:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: ____/____/____ Marital Status: _____ SSN: _____

Email: _____ How did you hear about us? _____

Insurance Information

Employer: _____ Insurance Company: _____

Insurance Address: _____ Insurance Phone: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: ____/____/____

Policy Holder's SSN: _____ Member ID#: _____

Group (Name/Number): _____

Patient Medical History

Physician: _____ **Office Phone:** _____ **Date of Last Visit:** ____/____/____

1. Are you allergic to any of the following?

☐ None/no allergies

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Latex
☐ Acrylic	☐ Metal	☐ Local anesthetics	☐ Sulfa drugs

☐ Other Please list: _____

2. Women – Are you:
   - ☐ Pregnant/Trying to get pregnant?
   - ☐ Taking oral contraceptives?
   - ☐ Nursing?

3. Are you currently under a physician's care? Yes / No If yes, please explain: _____

4. Have you recently been hospitalized? Yes / No If yes, please explain: _____

5. Are you taking any medication, pills or drugs? Yes / No Please list drugs: _____ _____ _____

6. Do you take, or have you taken, Phen-Fen or Redux? Yes / No

7. Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? Yes / No

8. Are you on a special diet? Yes / No If yes, please explain: _____

9. Do you use tobacco? Yes / No

10. Do you use controlled substances? Yes / No

11. Do you have, or have you had, any of the following?

☐ **NONE OF THESE APPLY**

☐ AIDS/HIV Positive	☐ Fainting Spells/Dizziness	☐ Lung Disease
☐ Alzheimer's Disease	☐ Frequent Cough	☐ Mitral Valve Prolapse
☐ Anemia	☐ Frequent Diarrhea	☐ Osteoporosis
☐ Angina	☐ Frequent Headaches	☐ Pain in Jaw Joints
☐ Arthritis/Gout	☐ Genital Herpes	☐ Parathyroid Disease
☐ Artificial Heart Valve	☐ Glaucoma	☐ Psychiatric Care
☐ Artificial Joint	☐ Heart Attack/Failure	☐ Radiation Treatments
☐ Asthma	☐ Heart Murmur	☐ Recent Weight Loss
☐ Blood Disease	☐ Heart Pacemaker	☐ Renal Dialysis
☐ Blood Transfusion	☐ Heart Trouble/Disease	☐ Rheumatic Fever

- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Dry Mouth
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease

Would you be interested in a FREE Skin Care Consultation? Yes / No

Would you be interested in receiving facial rejuvenation treatments? Yes / No
If yes, which conditions are you interested in having treated?
Age Spots ___ Rosacea ___ Broken Capillaries ___ Fine Lines & Wrinkles ___ Enlarged Pores ___ Sagging Skin ___Texture ____ Tone ____ Scars/Acne Scars ____ Loss of Volume ____ Other ____

Would you be interested in BOTOX→ Cosmetic wrinkle removing therapy? Yes___ No__
If yes, which facial areas would you be interested in having treated?
Forehead ___ Crow's Feet ___ Frown Lines (between the eyebrows) ___ Other ___
Would you be interested in dermal filler treatments? Yes___ No___
If yes, which facial areas would you be interested in having treated?
Smile Lines ___Vertical Lip Lines ___Lip Borders ___Under Eyes____ Cheeks____ Other ___

☐ **Yes! Please contact me with new information on cosmetic procedures, products and specials.**

Name _____ Signature _____

Cell Phone: _____ Zip Code _____

Email: _____

Patient Dental History

Name of Previous Dentist: _____ **Date of last exam:** ____/____/____

Location of Office: _____ **Date of last cleaning:** ____/____/____

1. Are you ever nervous during dental visits? (Please circle)

   Not Nervous Somewhat Nervous Extremely Nervous

2. Do you like your smile? Yes / No

3. Are you interested in changing your teeth? Yes / No

4. If yes, what would you like to change? (Please circle)

   Whiter Teeth Straighter Teeth Replace Missing Teeth

   Gaps or Spaces Misshapen Teeth Healthier Teeth

5. Do your gums bleed while brushing or flossing? Yes / No

6. Are your teeth sensitive to hot or cold? Yes / No

7. Do you snore or have you been told that you snore? Yes / No

8. Do you ever wake from sleep gasping for breath, or have you ever been told that you stop breathing while sleeping? Yes / No

9. Do you wear dentures or partials? Yes / No

   If yes, date of placement? ____/____/____

10. Do you clench or grind your teeth? Yes / No

11. When discussing your oral health, how would you like your information? (Please circle)

    Big Picture Some details I Want to Know Everything

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent of Guardian: _____ **Date:** ____/____/____

Broken Appointment Policy

When a patient does not show up for their appointment or cancels too close to their scheduled time, we are unable to give this appointment time to another patient who may want/need it. This policy is our attempt to ensure that both you and other patients receive the best dental care.

Broken Appointments:

- Broken appointments are any time you are scheduled for an appointment and you do not show up for that appointment.
- Late cancellations are considered broken appointments. If you need to cancel your appointment, a $75 fee will be charged, and we request a minimum of 48 hour notice of your cancellation.

Appointment Confirmation: Our practice uses automatic confirmation for appointments. Email, text, or phone reminders are sent for appointments for confirmation. It is important to respond to these so we can be sure to see all patients for their allotted appointment.

_____

Patient Name

_____ ____/____/____

Patient Signature Date