



Welcome to the Dental Spa of Dr. Garret Madderra. Good dental and esthetic health requires a broad understanding of your past and present general health. We appreciate you taking the time to complete this questionnaire. Thank you!

CONTACT INFORMATION

Name _____ Date _____
 Address _____ City/State/Zip _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Email _____ I prefer to be called _____
 Date of Birth _____ Age _____ SS# _____
 Is there someone we can thank for referring you? _____
 Contact person in case of emergency _____ Relation _____ Phone _____
 Employer Name _____ Type of work you do _____
 Employer's Address _____ City/State/Zip _____

MEDICAL HEALTH INFORMATION

Physician Name _____ Phone _____
 List all medications and supplements you are currently taking, including prescriptions, vitamins, herbal supplements, over-the-counter, and recreational drugs: _____

Have you ever taken the drug Phen-fen and/or Redux? Yes No
 Are you allergic to any of the following: Latex Penicillin / Amoxicillin Tetracycline Aspirin Dental Anesthetics
 Other allergies to medication / skin care ingredients: _____

Have you taken Accutane within the last 12 months? Yes No What dosage? _____

Do you bleed/bruise easily? Yes No

Have you ever had fever blisters or cold sores? Yes No How frequently? _____

If female: Are you taking birth control pills? Yes No Are you pregnant / trying to get pregnant? Yes No

Are you nursing? Yes No

Stress level: High Medium Low Quality of Sleep: Good Fair Poor

Do you smoke / use tobacco? Yes No # of glasses of water you drink a day? _____

Do you exercise regularly? Yes No # of alcoholic beverages you drink a week? _____

Please indicate whether you have or ever had any of the following medical conditions, diseases, or procedures:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Heart Attack / Stroke | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Cancer / Tumors | <input type="checkbox"/> Cosmetic Surgery |
| <input type="checkbox"/> Heart Surgery / Pacemaker | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles | <input type="checkbox"/> X-ray or Cobalt Treatment |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> HIV+ / AIDS / ARC | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Arthritis / Rheumatism | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Artificial Valves | <input type="checkbox"/> Stomach Problems / Ulcers | <input type="checkbox"/> Artificial Bones / Joints | <input type="checkbox"/> Diabetes / Hypoglycemia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Fainting / Seizures / Epilepsy | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Alcohol / Drug Abuse | <input type="checkbox"/> Severe / Frequent Headaches | <input type="checkbox"/> High / Low Blood Pressure |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis TB | <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Jaw Problems TMJ / TMD | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma |

Other surgeries or medical conditions you have or ever had: _____

DENTAL & ESTHETIC INFORMATION

Please indicate whether you have any of the following concerns:

- Discomfort, clicking or popping in jaw
- Red, Swollen &/or Bleeding Gums
- Blisters / Sores in &/or around the mouth
- Other: _____
- Lost / Broken Filling(s)
- Ringing in Ears
- Teeth Grinding
- Locking Jaw

Are you in pain? Yes No How long? _____

Do you require pre-medication? Yes No I don't know

Previous Dentist's Name _____ Phone _____

Date of Last Dental Exam _____ Date of Last Dental X-rays _____

of times a day you brush _____ # of times a week you floss _____

Type of Tooth Brush Bristles you use Soft Medium Hard Ultrasonic / Electric

Please indicate whether you had any of the following procedures within the last 12 months:

- Teeth Whitening
- Restylane Injections
- IPL Series
- Invisalign
- Perlane Injections
- Microdermabrasion
- Chemical Peel
- Sculptra Injections
- Laser Resurfacing
- Collagen Injections
- Botox Injections
- Facial Implants

Do you use sunscreen daily? Yes No SPF _____

Do you tan or go to a tanning salon? Yes No

Do you have a history of skin cancer? Yes No Type and Location: _____

Please indicate any of the following cosmetic concerns:

- Smile Symmetry
- Chapped / Cracked Lips
- Fine Line / Wrinkles
- Enlarged Pores
- Facial Redness / Rosacea
- Other: _____
- Gummy Smile
- Smile Brightening
- Smile Lines / Crows Feet
- Acne / Clogged Pores
- KP / Arm Bumps
- Broken / Chipped Tooth
- Vertical Lip Lines
- Smile Lines / Crows Feet
- Under Eye Circles
- Uneven Skin Tone
- Eczema
- Freshness of Breath
- Lip Fullness
- Scars
- Pigmentation
- Skin Sensitivity

INSURANCE INFORMATION

Company Name _____ Phone _____

Address _____ City/State/Zip _____

Insured's ID # _____ Group # (Plan, Local, or Policy) _____

Insured's Name _____ Relation _____ Date of Birth _____

Insured's Employer Name _____

PLEASE REVIEW BELOW POLICY INFORMATION AND SIGN THIS FORM

- We invite you to discuss with us any questions regarding our services. The best Dental and Esthetic health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I authorize the provider to release any information required to process insurance claims. I understand that Esthetic treatments received are cosmetic in nature and are not covered by any insurance company.
- I authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____

- Adult Patient
- Parent or Guardian
- Spouse