Cosmetic Implant Family

DENTISTRY

By John B. Sherman, DDS

We would like to extend a warm welcome to Sherman DDS the dental office of Dr. John Sherman. We are a full-service general and cosmetic dental practice. Sherman DDS offers a wide array of services ranging from basic exams to complete smile makeovers.

TELL US ABOUT YOU...

_____ Dr. _____Mr. ______Mrs. ______Ms.

Full Name: ____

I prefer to be called: ____________________________________

Who referred you to us: __________________________________

Birth date: ____/____/_____ _____ Male ____Female

Social Security Number: __________________________________

Address: ____

City:_________________________State________Zip____________

Email Address: ____

Home Number: (_______)__________________________________

Cell/Other: (_______)_____________________________________

Where and when is the best way to reach you? _________________

_____ Single _____Married _____Divorced _____Widowed

Occupation: ____

Employer: ____

Employer's Address: ______________________________________

Work Number: (______)_________________________Ext.__________

Spouse/Partner: ____

Spouse's Occupation: _____________________________________

Spouse's Employer: _______________________________________

In the event of an emergency, who should we contact?

Name: ____

Relation to you: ____

Work Number: (_______)___________________________________

Home Number: (_______)__________________________________

Cell Number: (_______)___________________________________

In the event that we cannot reach you directly, do you authorize Sherman DDS to leave a message for you? ☐Yes ☐No

DENTAL INSURANCE & INFORMATION...

Primary Dental Insurance Company:____________________________

Primary Subscriber Name: _________________________________

Subscriber ID Number: ___________________________________

Group Number: ____

Insured's Employer: ______________________________________

Insurance Co. Telephone Number: ___________________________

Insurance Claim Address: __________________________________

Do you have secondary dental insurance? ☐Yes ☐No

Please provide information on the last dentist you have seen:

Name____

Phone Number (_____)_____________________________________

Date Range Seen: ____

Types of Treatment: _______________________________________

What is the primary reason you came to our office today?

____

____

Are you currently experiencing any pain/discomfort? ☐Yes ☐No

Current Dental Health: ☐Good ☐Fair ☐Poor

Does food catch between your teeth? ☐Yes ☐No

Are your teeth sensitive to cold or sweets? ☐Yes ☐No

Any unpleasant experiences in a dental office? ☐Yes ☐No

If yes, please explain: ______________________________________

____

____

Y	N	Please answer the following questions by checking Yes or No:
		Are your teeth somewhat yellowed, darkened or stained? Have you ever experienced pain or discomfort in your jaw joint? (TMJ/TMD)
		Are there spaces between any of your teeth?
		Do you grind your teeth or are any of the biting edges on your teeth chipped or worn down?
		Do you have a "gummy" smile—showing too much gum tissue or having gums that are too thick?
		Are your gums red, puffy or do they bleed?
		Do you have an gray, black or silver (mercury) dental llings in your teeth that you want to replace?
		Do you have any old crowns that have dark edges at the top that don't really look natural?
		Do you smoke? How much/often?______________________
		Do you use smokeless tobacco? How much/often? _________
		Do you drink alcohol? How much/often? _______________

MEDICAL HISTORY...

Do you consider your current overall physical health to be:

☐Good ☐Fair ☐Poor

Are you currently under the active care of a physician or do you have any present health issues? ☐Yes No

Please explain: ____

Do you need to be pre-medicated with antibiotics for any heart or other medical conditions prior to dental treatment? ☐Yes ☐No

Are you taking any prescription or over-the-counter medications? (including Ibuprofen, diet supplements, etc.) ☐Yes ☐No

Please list each one: ____

____

Are you pregnant or nursing? ☐Yes ☐No

If pregnant, which trimester? ☐1st ☐2nd ☐3rd

What is your due date? ____

Have you ever had any of the following illnesses or medical problems in the past? Please check Yes or No:

Y	N		Y	N	
		Abnormal Bleeding			High Blood Pressure
		Alcohol/Drug Abuse			HIV+/AIDS
		Allergies			Hospitalization for any reason
		Anemia			Jaw Pain/TMJ
		Arthritis			Kidney Problems
		Artificial Bones/Joints/ Valves			Liver Disease
		Asthma			Low Back/Hips/Leg Pain
		Athletes Foot			Low Blood Pressure
		Blood Transfusion			Lupus
		Bone/Joint Disease			Mitral Valve Prolapse
		Bursitis			Neck/Shoulder/Arm Pain
		Cancer/Chemotherapy			Nervous Disorders
		Colitis			Pacemaker/ICD
		Congenital Heart Defect			Psychiatric Care
		Diabetes			Radiation Treatment
		Difficulty Breathing			Hepatitis
		Eating Disorders			Rashes
		Emphysema			Rheumatic/Scarlet Fever
		Epilepsy			Seizures
		Fainting Spells			Sexually Transmitted Disease
		Frequent Headaches			Shingles
		Gingivitis or Periodontal Disease			Sickle Cell Disease
		Glaucoma			Sinus Problems
		Hay Fever			Spasms/Cramps
		Headaches			Sprains/Broken Bones
		Heart Attack			Stomach Problems
		Heart Murmur			Stroke
		Heart Surgery			Tendonitis
		Hemophilia			Thyroid Problems
		Hepatitis ____ Type			Tuberculosis (TB)
		Herpes/Fever Blisters			Tumors
					Ulcers

Please list any significant medical condition(s) or surgeries that you have had (not already listed): ____

ALLERGIES...

Are you allergic to any of the following:

Y	N		Y	N	
		Aspirin			Latex
		Codeine			Penicillin
		Dental Anesthetics			Tetracycline
		Erythromycin			Any Metals
		Sulfites			Other

Please list any other drugs or items that you are allergic to:

____

____

Have you ever taken any of the following?

☐Phen-Fen ☐Vioxx ☐Fosamax ☐Cortico -Steroids ☐Tetracycline

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575.388.2515

EMAIL: INFO@SHERMANDDS.com

3115 LESLIE RD, SILVER CITY, NM 88061