Welcome to 20th Avenue Dentistry

About you

Name: _____Nickname: _____Male Female
Address: _____City:_____Zip:_____

Home Phone # :(___) _____ **Email Address**_____
Cell Phone # :(___) _____Work Phone # :(___) _____

Birthdate: ___/___/_____ Marital Status_____ SS#_____

Whom may we thank for referring you: _____?

Insurance Information

Employer: _____ Policy Holder's name: _____
Policy Holder's Birthdate___/___/____ Policy Holder's SS#_____
Insurance Company: _____ Group (Plan/Policy#) _____
Address: _____ City: _____ Zip: _____ INS Phone # :(___) _____

Medical History

Are you now or have you recently been under a physician's care? _____ yes _____ no
Reason: _____

Check any of the following medical conditions you may have had:

___Arthritis	___Hepatitis or Jaundice	___Prolonged bleeding
___Rheumatic Fever	___Smoke/Chewing tobacco	___Fainting tendency
___Heart trouble/Chest Pain	___Cancer or Tumor	___Epilepsy
___Heart Murmur/MVP	___Tuberculosis	___Thyroid Disease
___High/Low blood Pressure	___Diabetes	___Radiation treatment
___Mental disorders	___Stroke	___Kidney/bladder trouble
___HIV or AIDS	___Shortness of Breath	___Anemia
___Prosthetic joint replacement	___Asthma or Hay fever	___Lung Disease
___Blood Disease/transfusion	___Sinus Trouble	___Venereal Disease

Do you suffer from excessive tiredness during the day? __yes ___no
Have you ever been diagnosed with Obstructive Sleep Apnea (OSA)? ___yes ___no
Are you currently being treated for OSA? ___yes ___no
Are you aware of a family history of OSA? ___yes ___no
Are you aware of a clenching or grinding your teeth at night? ___yes ___no
Are you allergic to anything? ___yes ___no if yes, please list_____
Are you taking any medications? ____yes ____no if yes, please list_____
Are you pregnant? ____yes ____no if yes, how many months? _____Are you breast feeding? _____

Patient's signature: _____**Date** _____
I have read the office HIPPA policies? ___yes ___no

Dr. Michael Unser 7575 West 20th Ave. Lakewood, CO 80214 (303) 238-1400