Welcome!

Concord DENTAL CARE
G. Allen Herrera, D.D.S.

PATIENT INFORMATION

Mr / Mrs / Ms _____

Prefers to be called _____

Address _____

City _____ State _____ Zip _____

Birthdate ____ /____ /_____ Age _____

SSN #_____

Occupation_____

Employer /School _____

Address _____

Spouse or Parent's Name _____

CONTACT INFORMATION

Home Phone _____

Work Phone _____

Cell Phone _____

E-mail _____

In case of Emergency, contact:

Name _____ Phone _____

Relationship to Patient _____

HOW DID YOU HEAR OF US?

☐ Relative, if so whom? _____

☐ Friend, if so whom? _____

☐ Insurance Company ☐ Mailer ☐ Other _____

DENTAL INSURANCE

If not yourself, who is responsible for your account?

Name _____

Address _____

City _____ State _____ Zip _____

PRIMARY INSURANCE CARRIER

Insurance Co. _____

Ins. Address _____

Ins. Phone _____

Subscriber's Name _____

Birthdate ____ /____ /_____ SSN # _____

Relationship to Patient _____

Group # _____

Employer _____

SECONDARY INSURANCE CARRIER

Insurance Co. _____

Ins. Address _____

Ins. Phone _____

Subscriber's Name _____

Birthdate ____ /____ /_____ SSN # _____

Relationship to Patient _____

Group # _____

Employer _____

DENTAL HISTORY

Please list any dental problems or concerns: _____

Date of last Dental visit _____ /_____ Date of last Dental cleaning _____ /_____ Date of last Dental X-rays _____ /_____

Name of previous dentist_____ City _____ State _____

How often do you brush? ☐ regularly ☐ sometimes ☐ not enough How often do you floss? ☐ regularly ☐ sometimes ☐ not enough

Are you unhappy with the appearance of your teeth? ☐ Yes ☐ No If yes, what are you least happy about? _____

Do you feel nervous about having dental treatment? ☐ Yes ☐ No If yes, what is your biggest concern? _____

Have you ever had an upsetting dental experience? ☐ Yes ☐ No If yes, please describe: _____

Place a "✓" next to each item to indicate if you have or have had any of the following:

- ☐ Sensitivity to sweets
- ☐ Sensitivity to hot
- ☐ Sensitivity to cold
- ☐ Sensitivity to biting or chewing
- ☐ Bad breath or bad tastes
- ☐ Loose or broken teeth/fillings
- ☐ Burning sensation on tongue
- ☐ Trapped food between teeth
- ☐ Swollen, tender or bleeding gums
- ☐ Periodontal (gum) surgery
- ☐ Ear aches or neck pain
- ☐ Jaw pain or soreness
- ☐ Jaw clicking or popping
- ☐ Grinding teeth
- ☐ Mouth Breathing
- ☐ Lip or cheek biting
- ☐ Difficulty opening/closing
- ☐ Dry mouth
- ☐ Braces, bite plate or mouth guard
- ☐ Sores or blisters on lips or mouth

MEDICAL INFORMATION

Please stop and see the receptionist if you answer "yes" to any of the following:

Do you or have you had:

Active Tuberculosis	☐ Yes ☐ No
Persistent cough over 3 weeks	☐ Yes ☐ No
Cough that produces blood	☐ Yes ☐ No

Instructions: Please check "yes" or "no" to all items that you currently have or have had in the past.

Abnormal bleeding or easily bruised	☐ Yes ☐No
AIDS/HIV positive	☐ Yes ☐ No
Anemia	☐ Yes ☐ No
Angina	☐ Yes ☐ No
Anorexia/Bulimia	☐ Yes ☐ No
Arteriosclerosis	☐ Yes ☐ No
Arthritis/Rheumatoid arthritis	☐ Yes ☐ No
Artificial heart valves	☐ Yes ☐ No
Artificial joint replaced	☐ Yes ☐ No
Asthma	☐Yes ☐No
Blood transfusion	☐ Yes ☐ No
Cancer (Chemotherapy, Radiation Therapy)	☐ Yes ☐ No
Chest pain upon exertion	☐ Yes ☐ No
Chronic Pain	☐ Yes ☐ No
Congenital heart defect	☐ Yes ☐ No
Congenital heart failure	☐ Yes ☐ No
Coronary artery disease	☐ Yes ☐ No
Damaged heart valves	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No
Fainting spells or seizures	☐ Yes ☐ No
Gastrointestinal disease	☐ Yes ☐ No
GERD (Reflux)/Heartburn	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No
Heart attack	☐ Yes ☐ No
Heart disease	☐ Yes ☐ No
Heart murmur	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No
Low blood pressure	☐ Yes ☐ No
Hemophilia	☐ Yes ☐ No
Hepatitis/liver disease	☐ Yes ☐ No
Immunosuppresion	☐ Yes ☐ No
Kidney problems	☐ Yes ☐ No
Mental health disorders	☐ Yes ☐ No
Mitral valve prolapse	☐ Yes ☐ No
Neurological disorders	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No
Recurrent infections	☐ Yes ☐ No
Respiratory Disease (Emphysema, Bronchitis)	☐ Yes ☐No
Rheumatic Fever	☐ Yes ☐ No
Severe headaches/migraines	☐ Yes ☐ No
Severe or rapid weight loss	☐ Yes ☐ No
Sexually transmitted disease	☐ Yes ☐ No
Sinus trouble	☐ Yes ☐ No
Sleep disorders/night sweats	☐ Yes ☐ No
Stroke	☐ Yes ☐ No
Swollen neck glands	☐ Yes ☐ No
Systemic lupus/ Erythematosus	☐ Yes ☐ No
Thyroid problems	☐ Yes ☐ No
Ulcers	☐ Yes ☐ No
Urination, excessive	☐ Yes ☐ No

1. Is your general health good? ..... ☐ Yes ☐ No If no, please explain _____

   Physician's Name _____ Phone _____ Last check-up _____/_____

2. Have you gone to the hospital or emergency room or had a serious illness within the last three years? ..... ☐ Yes ☐ No

3. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? …… ☐ Yes ☐ No
   If yes, why? _____

4. Are you taking any over the counter, prescription or herbal medication, drugs or pills now? ……..……..... ☐ Yes ☐No
   If yes, please list: _____

5. Do you smoke or chew tobacco?..... ☐ Yes ☐ No If yes, how often? _____ /day Are you interested in stopping? ☐ Yes ☐ No

6. Have you or do you currently drink alcohol?..... ☐ Yes ☐ No

7. Have you or do you currently use non-prescribed drugs?..... ☐ Yes ☐ No

8. Have you ever taken diet drugs (Phen-fen, Redux) or bisphosphonates (Fosamax, Actonel)? ..... ☐ Yes ☐ No

9. Have you ever had an **allergic or adverse** reaction to: (Check all that apply) ☐ aspirin ☐ ibuprofen ☐ codeine ☐ iodine
   ☐ local anesthetics ☐ penicillin/amoxicillin ☐ sulfa drugs ☐ tetracycline ☐ latex, plastic or metals ☐ other _____

10. Women: Are you Pregnant? ☐ Yes, due on __ /__ ☐ Maybe ☐ No Are you Nursing? ☐ Yes ☐ No Do you use Birth Control? ☐ Yes ☐ No

11. Do you have any disease, medical conditions, or problem not listed?…….……..…… ☐ Yes ☐ No

12. **Is there any issue or condition that you would like to discuss with the doctor in private? …..…… ☐ Yes ☐ No**

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature_____ Date_____

Doctor's Signature __ _____ Date _____