

# WELCOME

Thank you for selecting our dental healthcare team!  
We will strive to provide you with the best possible dental care.  
To help us meet all your dental needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us, we will be happy to help.

E-mail Address: \_\_\_\_\_

## ABOUT YOU

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Last First Middle Mr Mrs Ms Dr

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Single Married Divorced Widowed Separated

Home Address: \_\_\_\_\_  
Street/PO Box City State Zip  
Home Phone #:(\_\_\_\_) Pager/Cell #:(\_\_\_\_) Work Phone #:(\_\_\_\_) Ext:\_\_\_\_  
Where & when are best times to reach you? \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_  
Other family members seen by us: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
Street/ PO Box City State Zip

### Neighbor or Relative not living with you

His/Her Name: \_\_\_\_\_ Work Phone #:(\_\_\_\_) Home Phone #:(\_\_\_\_)  
Address: \_\_\_\_\_ Relation: \_\_\_\_\_  
Street City State Zip

## SPOUSE INFORMATION

His/Her Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone #: (\_\_\_\_) Ext \_\_\_\_\_

## INSURANCE INFORMATION

**Primary Insurance** Dental Coverage? Yes No Ortho Coverage? Yes No Medical Coverage? Yes No  
Insurance Co.: \_\_\_\_\_ Phone#: (\_\_\_\_) Max(\$): \_\_\_\_\_ Deductible(\$): \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ Group#: \_\_\_\_\_  
Street/PO Box City State Zip  
Insured's Name: \_\_\_\_\_ Social Security#: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_ Relation: \_\_\_\_\_  
Street/PO Box City State Zip

**Secondary Insurance**  
Insurance Co.: \_\_\_\_\_ Phone#: (\_\_\_\_) Max(\$): \_\_\_\_\_ Deductible(\$): \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ Group#: \_\_\_\_\_  
Street/PO Box City State Zip  
Insured's Name: \_\_\_\_\_ Social Security#: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_ Relation: \_\_\_\_\_  
Street/PO Box City State Zip

## Dental History

Why have you come to the dentist today? \_\_\_\_\_

Are you currently in pain?  Yes  No  
**Do you require antibiotics before dental treatment?**  Yes  No  
 Your current dental health is:  Good  Fair  Poor  
 Do you floss daily?  Yes  No Brush daily?  Yes  No  
 Type of bristles on your toothbrush?  Hard  Med  Soft  
 Do your gums ever bleed?  Yes  No Ever Itch  Yes  No  
 Have you ever had periodontal (gum) disease?  Yes  No

Are your teeth sensitive to heat, cold, or anything else? \_\_\_\_\_  
 Do you have loose teeth?  Yes  No  
 Do you still have wisdom teeth?  Yes  No  
 Previous / Present Dentist: \_\_\_\_\_ Last Visit Date: \_\_\_\_\_  
 (Please Circle)  
 Would you like fresher breath?  Yes  No Whiter teeth?  Yes  No  
 Are you happy with the way your smile looks?  Yes  No  
 If not, what would you change? \_\_\_\_\_

Do you have a personal physician?  Yes  No  
 Physician's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone#: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
**Your current physical health is:**  Good  Fair  Poor

Are you currently under the care of a physician?  Yes  No  
 Please explain: \_\_\_\_\_  
 Do you smoke or use tobacco in any other form?  Yes  No  
 Have you ever take Phen-Fen / Redux?  Yes  No  
**For Women:** Are you taking birth control pills?  Yes  No  
 Are you pregnant?  Unsure  Yes  No  
 Week #: \_\_\_\_\_ Are you nursing?  Yes  No

Please list any serious medical condition(s) that you have experienced:

### Do you or have you experienced the following? (Please circle yes or no)

Y N Abnormal Bleeding	Y N Colitis	Y N Hay Fever	Y N Liver Diseases	Y N Shingles
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Headaches	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Attack	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Heart Surgery	Y N Pacemaker	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hemophilia	Y N Persistent Cough	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Hepatitis A B C	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Herpes	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Cancer	Y N Fainting Spells	Y N High Blood Pressure	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Fever Blisters	Y N HIV+ / AIDS	Y N Scarlet Fever	Y N Venereal Disease
Y N Chicken Pox	Y N Glaucoma	Y N Kidney Problems	Y N Seizures	Other _____

Are you taking any prescription / over the counter drugs?  Yes  No If yes, please list each one: \_\_\_\_\_

### Are you allergic to any of the following? (Please circle yes or no)

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry / Metals	Y N Penicillin	Y N Sulfa Drugs	Y N Other

Please list any additional allergies: \_\_\_\_\_

### Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services at the time that they are rendered, any deductible, and co-payment that my insurance does not cover.

**I have received a copy of this offices Notice of Privacy Practices and the Dental Board of California Dental Material Fact Sheet.**

X \_\_\_\_\_  
 Patient Signature Date Doctor Signature Date

**Health History Update** (Please review form and sign below at next dental cleaning appointment. It is imperative that you please inform the doctor and staff of all changes in your health since your last visit, including new medications and surgical procedures.)

I have read my medical history dated \_\_\_\_\_ and I confirm that it states past and present medical condition.

X \_\_\_\_\_  
 Patient Signature Date Doctor Signature Date