Randhawa Dental Corporation
4138 Dyer St. suite 1 Union City, CA 94587

Gurjit S. Randhawa D.D.S., M.D.S.
Aneet Randhawa D.D.S., M.D.S.

HOW DID YOU FIND OUT ABOUT OUR OFFICE? PLEASE CHECK ONE: ☐ POSTCARD/FLYER ☐ WEBSITE
☐ FRIEND/FAMILY PLEASE NAME:______________________ ☐ NEWSPAPER ☐ OTHER_____________________

PATIENT INFORMATION

PATIENT'S NAME____
FIRST MIDDLE LAST

PATIENT'S ADDRESS____ HOME PHONE #_________________________
STREET CITY STATE ZIP

BUSINESS PHONE #________________________ CELL PHONE#_____________________EMAIL ADDRESS__________________________________

BEST TIME TO REACH YOU: __________________________ BEST DAY: __________________________WHERE:_____________________________

EMPLOYER/ OCCUPATION NAME ____

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE___________________________CITY________________STATE________ZIP_____________

SOC. SEC. #___________________________ MALE MARRIED?

DATE OF BIRTH_______________________ FEMALE YES NO

SPOUSE'S NAME: _______________________________________RELATIONSHIP___________________________PHONE#______________________

EMPLOYER/OCCUPATION NAME_____________________________________BUSSINESS PHONE #____

DATE OF BIRTH ___________________________SOC. SEC. #________________________________ DRIVER LICENSE#________________________

IF PATIENT IS MINOR, GIVE:
PARENT/GUARDIAN NAME: ______________________________________ RELATIONSHIP______________________PHONE#___________________

EMPLOYER/OCCUPATION NAME_____________________________________BUSSINESS PHONE#____

DATE OF BIRTH___________________________SOC. SEC. #________________________________DRIVER LICENSE #_________________________

INSURANCE INFORMATION

DO YOU HAVE DENTAL INSURANCE ………………………………………….YES NO

NAME OF INSURED: ___________________________________INSURED DOB: __________________INSURED SOC.SEC. #_____________________

NAME OF INSURANCE COMPANY____PHONE #____

POLICY/GROUP#____LOCAL #____

DO YOU HAVE A SECOND DENTAL INSURANCE ……………………………….YES NO

NAME OF INSURED: ___________________________________INSURED DOB: __________________INSURED SOC.SEC. #_____________________

NAME OF INSURANCE COMPANY____PHONE #____

POLICY/GROUP#____LOCAL #____

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

NAME____RELATIONSHIP____

HOME TEL#_________________________________BUSINESS TEL #___________________________CELL PHONE #__________________________

NAME ____RELATIONSHIP____

HOME TEL#_________________________________BUSINESS TEL #___________________________CELL PHONE#___________________________

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MEDICAL HISTORY

THESE QUESTIONS ARE FOR YOUR BENEFIT AND ASSURE THE TREATMENT WILL TAKE INTO CONSIDERATION YOUR PAST AND PRESENT HEALTH STATUS. SOME QUESTIONS MAY SEEM UNREALTED TO YOUR DENTAL CONDITION, BUT THEY ARE ALL ASSOCIATED WITH PROPER ORAL HEALTHCARE. PLEASE ANSWER EACH QUESTION.

____

NAME OF PHYSICIAN CITY PHONE# DATE OF LAST PHYSICAL

HAVE YOU EVER HAD ANY SERIOUS ILLNESS OR OPERATION? YES NO
IF YES, WHAT ILLNESS, OPERATION OR PROBLEM ____

ARE YOU TAKING ANY DRUGS OR MEDICINE? YES NO IF SO, WHAT? ______________________________

ARE YOU SENSITIVE OR ALLERGIC TO ANY DRUGS? YES NO IF YES, WHICH DRUGS? *PENICILLIN* *TETRACYCLINE*

ANESTHETIC (NOVOCAIN, ETC.) *SULFA DRUGS* *ASPIRIN* *CODEINE* *OTHER*____________________

ARE YOU SENSITIVE TO LATEX? YES NO

HAVE YOU EVER TAKEN PRESCRIPTION MEDICATION FOR WEIGHT LOSS (DIET PILLS) YES NO

IF YES, DID YOU TAKE ANY OF THE FOLLOWING?
FEN-PHEN (FENFLURAMINE-PHENPETMINE YES NO
PONDIMINE (FENFLURAMINE) YES NO
REDUX (DEXFENFLURAMINE) YES NO

DO YOU WEAR A CARDIAC PACEMAKER, OR HAVE YOU HAD HEART SURGERY YES NO WHEN? ____________________

ARE YOU REQURIED TO TAKE ANY MEDICATION BEFORE YOUR DENTAL VISIT? YES NO WHAT? ____________________

(WOMAN) ARE YOU PREGNANT? YES NO IF SO, HOW MANY MONTHS? ____________________

DO YOU HAVE OR HAVE ANY OF THE FOLLOWING? (PLEASE CIRCLE "YES" OR "NO"):

YES/NO *ANEMIA*	YES/NO *HEAD INJURIES*	YES/NO *CEREBRAL PALSY*	YES/NO *EPILEPSY OR SEIZURES*
YES/NO *HERPES*	YES/NO *HEART FAILURE*	YES/NO *JOINT REPLACEMENT*	YES/NO *ARTIFICAL PROSTHESIS*
YES/NO *STROKE*	YES/NO *LIVER DISEASE*	YES/NO *NERVOUS DISORDER*	YES/NO *PSYCHIATRIC TREATMENT*
YES/NO *ULCERS*	YES/NO *SCARLET FEVER*	YES/NO *TUMORS OR GROWTHS*	YES/NO *CONGENITAL HEART DISEASE*
YES/NO *DIABETES*	YES/NO *CHICKEN POX*	YES/NO *ALLERGIES OR HIVES*	YES/NO *HEART AILMENTS OR ATTACK*
YES/NO *GLAUCOMA*	YES/NO *SINUS TROUBLE*	YES/NO *EXCESSIVE BLEEDING*	YES/NO *X-RAY OR COBALT TREATMENT*
YES/NO *ARTHRITIS*	YES/NO *BLOOD DISEASE*	YES/NO *ASTHMA*	YES/NO *FAINTING SPELLS OR SEIZURES*
YES/NO *EMPHYSEMA*	YES/NO *DRUG ADDICTION*	YES/NO *HIGH BLOOD PRESSURE*	YES/NO *CHEMOTHERAPY (CANCER, LEUKEMIA)*
YES/NO *HAYFEVER*	YES/NO *KIDNEY DISEASE*	YES/NO *AIDS RELATED COMPLEX*	YES/NO *RADIATION TREATMENT*
YES/NO *TONSILLITIS*	YES/NO *ANGINA PECTORIS*	YES/NO *RESPIRATORY DISEASE*	YES/NO *HEPATITIS OR JAUNDICE*
YES/NO *HEMOPHILIA*	YES/NO *RHEUMATIC FEVER*	YES/NO *SICKLE CELL DISEASE*	YES/NO *VENEREAL DISEASE*
YES/NO *HEART MURMUR*	YES/NO *THYROID DISEASE*	YES/NO *TUBERCULOSIS (TB)*	YES/NO *OTHER* ____________

DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK WE SHOULD KNOW ABOUT?

YES NO IF YES, WHAT? ____

DENTAL HISTORY

____

NAME OF DENTIST (PREVIOUS) CITY PHONE# DATE OF LAST VISIT
PLEASE LIST ANY PREVIOUS EXPERIENCES OR PROBLEMS YOU WOULD LIKE THE DOCTOR TO BE AWARE OF

PLEASE EXPLAIN____

HOW LONG SINCE YOUR LAST FULL MOUTH X-RAY? ____
DOES DENTAL TREATMENT MAKE YOU NERVOUS? SLIGHTLY MODERATELY EXTERMELY NO

THE INFORMATION AND HEALTH HISTORY AND PRECEDING ANSWERS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE AND GIVE CONSENT TO PREFORM DENTAL SERVICES AGREED BETWEEN DOCTOR AND PATIENT AND/OR GUARDIAN TO BE NECESSARY OR ADVISABLE, INCULUDING THE USE OF LOCAL ANESTHESIA AND OTHER MEDICATIONS AS INDICATED. I AGREE THAT, REGARDLESS OF INSURANCE COVERAGE, I AM RESPONSIBLE FOR PAYMENT FOR SERVICES RENDERED. IF I EVER HAVE ANY CHANGES IN MY HEALTH OR IF MY MEDACATION CHANGE I WILL, WITHOUT FAIL, INFORM THE DOCTOR AT MY NEXT APPOINTMENT.

SIGNATURE: ______________________________ DATE: ______________________

YEAR 2: CHANGES IN HEALTH______________________________
DATE: ______________ SIGNATURE______________________________
YEAR 3: CHANGES IN HEALTH______________________________
DATE: ______________ SIGNATURE______________________________
HEALTH QUESTIONNAIRE MUST BE UPDATED EACH YEAR

OFFICE USE ONLY
(YEAR 1) INITIALS______________ DATE: ______________
(YEAR 2) INITIALS______________ DATE: ______________
(YEAR 3) INITIALS______________ DATE: ______________