ADULT PATIENT QUESTIONNAIRE

NAME__________________________Home PH.__________Cell PH.___________

MAILING ADDRESS____________________Work PH.______________________

CITY_______________________STATE__________ZIP______________________

PHYSICAL ADDRESS____

SS#______________________BIRTHDATE__________Marital Status__________

DRIVER'S LICENSE #____________________________EXP DATE___________
EMAIL_________________________________
EMPLOYER_____________________________________DEPT________________
WHO MAY WE THANK FOR REFERRING YOU_______________________OR
HOW DID YOU HEAR ABOUT OUR OFFICE? _______________________
IF PHONE BOOK WHICH ONE? AT&T (BIG)_____TAHOE DIR (SMALL)_____
NEAREST RELATIVE NOT LIVING WITH YOU: NAME__________________
ADDRESS___________________________________PHONE #_________________

IN CASE OF AN EMERGENCY CONTACT: NAME________________________

PHONE #______________________________RELATIONSHIP________________

INSURANCE INFORMATION

INSURED PERSON__________________SS#_________________BD__________
INSURED PERSON MAILING ADDRESS________________________________
EMPLOYER_________________________DEPT____________________________
DENTAL INSURANCE CO__________________GROUP #___________________
INSURANCE ADDRESS_______________________PH #____________________

*************DO YOU HAVE DUAL INSURANCE?____YES____NO**************
IF YES, COMPLETE FOLLOWING.

INSURED PERSON_________________SS#_________________BD___________
EMPLOYER______________________________DEPT________________________
SECOND INSURANCE CO___________________________GROUP #__________
INSURANCE ADDRESS____________________________PH #_______________
****

PLEASE READ AND SIGN FOLLOWING

CONSENT:

I the undersigned hereby authorize Chris Cerceo D.D.S. or Jeanie F. Kaufman D.D.S. to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Drs. Cerceo or Kaufman to make a thorough diagnosis of my dental needs. I also authorize Drs. Cerceo or Kaufman to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with (Name of Patient) ____________________, and further authorize and consent that The Doctors choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. It is also my understanding that all x-rays are permanent records of this office. To transfer records, there will be a duplication fee and records will only be transferred if my account balance is zero.

SIGNATURE____DATE______________________

ADULT PATIENT QUESTIONNAIRE

NAME________________________ Home PH.__________ Cell PH.__________

MAILING ADDRESS____________________ Work PH.____________________

CITY________________________ STATE__________ ZIP____________________

PHYSICAL ADDRESS____

SS#_______________________ BIRTHDATE__________ ZIP____________________

DRIVER'S LICENSE #__________________________ EXP DATE___________

EMPLOYER______________________________________ DEPT________________
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ADDRESS______________________________________ PHONE #__________________

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PHONE #________________________________ RELATIONSHIP___________________
EMAIL____________________________________

INSURANCE INFORMATION

INSURED PERSON___________________ SS#____________________ BD___________
INSURED PERSON MAILING ADDRESS_______________________________________
EMPLOYER___________________________ DEPT________________________________
DENTAL INSURANCE CO____________________ GROUP #______________________
INSURANCE ADDRESS__________________________ PH #_______________________

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IF YES, COMPLETE FOLLOWING.

INSURED PERSON___________________ SS#____________________ BD____________
EMPLOYER_________________________________ DEPT____________________________
SECOND INSURANCE CO________________________________ GROUP #____________
INSURANCE ADDRESS__________________________________ PH #__________________
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SIGNATURE____ DATE_______________________

CHILD PATIENT QUESTIONNAIRE

CHILD'S NAME______________________ BIRTHDATE__________________
PERSON ACCOMPANYING CHILD TODAY IS RESPONSIBLE FOR PAYMENT
RELATIONSHIP________________
NAME________________________ Home PH.__________ Cell PH.____________

MAILING ADDRESS____________________ Work PH.______________________

CITY______________________ STATE__________ ZIP______________________

PHYSICAL ADDRESS____

SS#______________________ BIRTHDATE__________ ZIP____________________

DRIVER'S LICENSE #____________________________ EXP DATE____________

EMPLOYER______________________________________ DEPT________________
WHO MAY WE THANK FOR REFERRING YOU_______________________ OR
HOW DID YOU HEAR ABOUT OUR OFFICE? ____________________________
IF PHONE BOOK WHICH ONE? AT&T (BIG)____ TAHOE DIR (SMALL)____

NEAREST RELATIVE NOT LIVING WITH YOU: NAME____________________
ADDRESS___________________________________ PHONE #_________________

IN CASE OF AN EMERGENCY CONTACT: NAME________________________
PHONE #______________________________ RELATIONSHIP________________
EMAIL________________________________

INSURANCE INFORMATION

INSURED PERSON__________________ SS#__________________ BD___________
INSURED PERSON MAILING ADDRESS__________________________________
EMPLOYER__________________________ DEPT______________________________
DENTAL INSURANCE CO____________________ GROUP #____________________
INSURANCE ADDRESS_________________________ PH #______________________

*************DO YOU HAVE DUAL INSURANCE?___YES___NO**************
IF YES, COMPLETE FOLLOWING.

INSURED PERSON__________________ SS#____________________ BD_____________
EMPLOYER________________________________ DEPT____________________________
SECOND INSURANCE CO_______________________________ GROUP #___________
INSURANCE ADDRESS__________________________________ PH #__________________
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SIGNATURE____ DATE______________________

Tahoe Family Dentists
Medical History

ASA Classification	
I	**WNL**
II	**Slight**
III	**Moderate**
IV	**Severe**
V	**Non Treat**

Date ____________

Med Alert ____________

Patient's Name ____________ Birthdate ____________

Physician Name ____________ Ph # ____________ Closest Relative ____________ Ph # ____________

Any serious problems associated with dental treatment? ____________

Yes, explain ____________ Current Pain: ____________

Reason for visit ____________ Last dental visit ____________ Last dental X-rays ____________

Do you experience any of the following problems with your jaw joints that you feel should be examined; if so, where?

Circle what applies: Popping; clicking; grating; locking; muscle, facial, throat or neck pain; clenching or grinding?

GENERAL HEALTH HISTORY; *PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS. DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS:*

Cardiovascular Disorders:

Yes	No	
☐	☐	High blood pressure
☐	☐	Congenital heart disease
☐	☐	Rheumatic fever
☐	☐	Heart murmur/valve problem
☐	☐	Heart pacemaker
☐	☐	Vascular graft
☐	☐	Heart or bypass surgery
☐	☐	Artificial heart valve
☐	☐	Heart attack
☐	☐	Congestive heart failure
☐	☐	Awaken with breathing difficulty
☐	☐	Angina Pectoris/chest pain
☐	☐	Swollen ankles
☐	☐	Irregular or rapid heart beats
☐	☐	Stroke

Respiratory Disorders:

Yes	No	
☐	☐	Emphysema or asthma
☐	☐	Hay fever
☐	☐	Chronic cough or bronchitis
☐	☐	Tuberculosis (TB)
☐	☐	Chronic sinusitis
☐	☐	Asthma/Breathing problems

Musculo-Skeletal/CNS/ Developmental Disorders;

Yes	No	
☐	☐	Frequent headaches
☐	☐	Fainting spells or loss of consciousness
☐	☐	Seizures or epilepsy
☐	☐	Visual impairment
☐	☐	Hearing impairment
☐	☐	Artificial joint
☐	☐	Arthritis or bone disease
☐	☐	Muscle disease
☐	☐	Spinal cord injury or paralysis
☐	☐	Cerebral palsy
☐	☐	Mental retardation/autism
☐	☐	Alzheimer's disease or other dementia

Gastrointestinal/Genitourinary Disorders:

Yes	No	
☐	☐	Colitis or ulcers
☐	☐	Hepatitis or other liver disease
☐	☐	Jaundice
☐	☐	Renal dialysis/transplant
☐	☐	Kidney disease
☐	☐	Syphilis, gonorrhea or other sexually transmitted diseases
☐	☐	Genital herpes
☐	☐	Frequent canker sores
☐	☐	Frequent cold sores
☐	☐	Chronic diarrhea
☐	☐	Frequent vomiting

Hematologic/Endocrine/Immune Disorders:

Yes	No	
☐	☐	Blood transfusion
		Denied permission to give blood
☐	☐	Anemia/leukemia/lymphoma
☐	☐	Hemophilia
☐	☐	Sickle cell disease
☐	☐	Blood clots or thrombosis
☐	☐	Diabetes
☐	☐	Thyroid disease
☐	☐	Adrenal gland disease
☐	☐	AIDS
☐	☐	HIV infection
☐	☐	Bleeding or bruising tendency
☐	☐	Sudden weight loss or gain
☐	☐	Frequent thirst
☐	☐	Frequent hunger
☐	☐	Frequent urination
☐	☐	Cancer/radiotherapy
☐	☐	Chemotherapy
☐	☐	Systemic lupus

Psychiatric:

Yes	No	
☐	☐	Nervousness
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Past/present psychiatric treatment

Family History (Grandparents, Parents, Sisters, Brothers, Children):

Yes	No	
☐	☐	Diabetes
☐	☐	Heart disease
☐	☐	Bleeding disorders

Allergies:

Yes	No	
☐	☐	Penicillin
☐	☐	Sulfa drugs
☐	☐	Novocaine/Xylocaine dental anesthetics
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Latex
☐	☐	Other ____________

Females:

Yes	No	
☐	☐	Are you pregnant now? _______ # months
☐	☐	Are you practicing birth control?
☐	☐	Do you anticipate becoming pregnant?
☐	☐	Are you breast feeding now?

DENTAL HISTORY

Yes	No	
☐	☐	Are you having pain or discomfort related to your mouth?
☐	☐	Do you feel nervous about having dental treatment?
☐	☐	Have you ever had a bad experience in a dental office?

WOULD YOU PREFER ANY OF THE FOLLOWING FOR DENTAL PROCEDURES:

Yes	No	
☐	☐	Oral Sedation
☐	☐	Nitrous Oxide
☐	☐	I.V. Twilight Sleep

Have you ever taken Phen-fen? ____________

Any medical problems, history of hospitalization and/or surgical procedures in the last five years? Explain: ____________

____

Current Medications: Prescribed and over the counter medications taken within the last six months. Including Birth Control pills.

____

____

____

PLEASE DESCRIBE HOW WE MAY MAKE YOUR DENTAL TREATMENT MORE COMFORTABLE AND PLEASANT

____

Are you happy with the appearance of your teeth? _____ Like to Improve? ____________

SIGNED: ____________
Signature

Medical History Update: Date ____________ Changes ____________