PLEASE ANSWER EACH QUESTION COMPLETELY

PATIENT INFORMATION

NAME ______________________________ NICKNAME ____________________

SOC. SEC. NO. ____________________ BIRTHDATE ______________ SEX: M _____ F_____

HOME PH (   ) ______________ CELL PH (   ) ______________ WORK PH (   ) ______________

ADDRESS______________________________ CITY ______________ ZIP ____________

SCHOOLS (If full time student) ____

PREVIOUS DENTIST __________________ CITY ________________ LAST VISIT ____________

IN CASE OF EMERGENCY, PLEASE CONTACT ____________________ PHONE (   ) ____________

☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ CHILD ☐ WIDOWED

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?______________________

INSURANCE INFORMATION

PRIMARY INSURANCE *OR PERSON RESPONSIBLE FOR ACCOUNT*

NAME______________________________ RELATIONSHIP TO PATIENT ______________

OCCUPATION ____________________ SOC. SEC. NO. ______________ BIRTHDATE ____________

EMPLOYER ______________________ ADDRESS ______________________________

CITY ____ ZIP______________

WORK PH (   ) ______________ CELL PH (   ) ______________ HOME PH (   ) ______________

INSURANCE COMPANY ______________________________ GRP. NO. __________________

SECONDARY INSURANCE *Fill out if patient is covered by another insurance plan.*

NAME______________________________ RELATIONSHIP TO PATIENT ______________

OCCUPATION ____________________ SOC. SEC. NO. ______________ BIRTHDATE ____________

EMPLOYER ______________________ ADDRESS ______________________________

CITY ____ ZIP______________

WORK PH (   ) ______________ CELL PH (   ) ______________ HOME PH (   ) ______________

INSURANCE COMPANY ______________________________ GRP. NO. __________________

ACKNOWLEDGEMENT & AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, X-ray, or other studies that may be used by the attending doctor, or his qualified designate.

I also acknowledge full responsibility for the payment of such services, whether I have insurance coverage or not, and I agree to pay for them, in full, **at the time of service,** unless other arrangements are made. I understand that accounts more than 60 days overdue are subject to a service charge of $5.00, and I am responsible for attorney's fees, collection fees, or court costs incurred in the collection of a delinquent account. I understand that where appropriate, a credit check may be made through a credit bureau.

✕ Signed: ______________________________________ Date: ____________________

INSURANCE RELEASE

✕ Signed: ____________________
Date: ____________________

I hearby authorize insurance benefit payments directly to Ricardo S. De Ala D.D.S. for his services. I am financially responsible for the charges not covered. A copy of this authorization shall be as valid as the original.

✕ Signed: ____________________
Date: ____________________

I authorize Ricardo S. De Ala D.D.S. to release to the insurance company any information required in the course of examination or treatment relating to my insurance claim.

RICARDO S. DE ALA, D.D.S., 39453 Fremont Blvd., Fremont, CA 94538, Tel. (510) 657-8907

PATIENT HEALTH HISTORY

How would you describe your health? ______________________ Date of last Medical Exam: __________

Name of Physician ______________________

		YES	NO
1.	Are you now or have you been under the care of a physician within the past five years? If so, why? _________	☐	☐
2.	Have you had any major surgery or hospitalization? __________	☐	☐
3.	Are you now or have you recently been taking any medication? If so, for what? __________	☐	☐
4.	Have you taken Phen-fen before? When? Have you seen your physician after that? __________	☐	☐

5. Are you allergic to or have any reactions to any of the following: (*mark each applicable box)*

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Local Anesthetics (e.g. Novocaine)	☐	☐	Aspirin	☐	☐	Iodine	☐	☐	Others (please list)__________
☐	☐	Penicillin or any other antibiotics__________	☐	☐	Codeine	☐	☐	Any metals (e.g. nickel, mercury)	☐	☐	__________
☐	☐	Sulfa Drugs	☐	☐	Barbituates	☐	☐	Latex rubber			
			☐	☐	Sedatives						

6. **WOMEN ONLY:**

	YES	NO
a. Are you pregnant or think you may be pregnant? .... Due Date	☐	☐
b. Are you nursing?........	☐	☐
c. Are you taking oral contraceptives?........	☐	☐

7. **DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:** *(mark each applicable box)*

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Heart Attack	☐	☐	Joint	☐	☐	Cortisone Medicine	☐	☐	Gonorrhea
☐	☐	Heart Failure	☐	☐	Replacement/Implant	☐	☐	Glaucoma	☐	☐	Cold Sores
☐	☐	Heart Surgery	☐	☐	Kidney Trouble	☐	☐	Pain in Jaw Joings	☐	☐	Genital Herpes
☐	☐	Heart Disease	☐	☐	Ulcers	☐	☐	Epilepsy or Seizures	☐	☐	Fainting/Dizzy Spells
☐	☐	Angina Pectoris	☐	☐	Arthritis	☐	☐	Aids or HIV Infection	☐	☐	Nervousness
☐	☐	Heart Murmur	☐	☐	Emphysema	☐	☐	Hepatitis A (infections)	☐	☐	Psychiatric Treatment
☐	☐	High Blood Pressure	☐	☐	Tuberculosis	☐	☐	Hepatitis B (serum)	☐	☐	Sickle Cell Disease
☐	☐	Rheumatic Fever	☐	☐	Asthma	☐	☐	Liver Disease	☐	☐	Bleeding Gums
☐	☐	Congenital Heart Defect	☐	☐	Hay Fever/Allergies	☐	☐	Yellow Jaundice	☐	☐	Tooth Pain
☐	☐	Scarlet Fever	☐	☐	Sinus Trouble	☐	☐	Blood Transfusion	☐	☐	Bad Breath
☐	☐	Artificial Heart Valve	☐	☐	Diabetes	☐	☐	Drug Addiction	☐	☐	Chronic Headaches
☐	☐	Mitral Valve Prolapse	☐	☐	Thyroid Disease	☐	☐	Hemophilia	☐	☐	Chronic Neckaches
☐	☐	Heart Pace Maker	☐	☐	Radiation Treatment	☐	☐	Syphilis	☐	☐	Cosmetic Surgery
☐	☐	Stroke	☐	☐	Chemotherapy	☐	☐	Leukemia	☐	☐	Others not listed: __________
			☐	☐	Cancer						

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location ______________________ Date of Last Exam __________

		YES	NO
1.	Do your gums bleed while brushing or flossing?	☐	☐
2.	Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3.	Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4.	Do you feel pain to any of your teeth?	☐	☐
5.	Do you have any sores or lumps in or near your mouth?	☐	☐
6.	Have you had any head, neck or jaw injuries?	☐	☐
7.	Have you ever experienced any of the following problems in your jaw?		
	Clicking	☐	☐
	Pain (joint, ear, side of face)........	☐	☐
	Difficulty in opening or closing........	☐	☐
	Difficulty in chewing........	☐	☐

		YES	NO
8.	Do you have frequent headaches?	☐	☐
9.	Do you clench or grind your teeth?	☐	☐
10.	Do you bite your lips or cheeks frequently?	☐	☐
11.	Have you ever had any difficult extractions in the past?	☐	☐
12.	Have you ever had any prolonged bleeding following extractions?	☐	☐
13.	Have you had any orthodontic treatment?	☐	☐
14.	Do you wear dentures or partials? If yes, date of placement__________	☐	☐
15.	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16.	Do you like your smile?	☐	☐

Authorization and Release *I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners.*

Signature of Patient/Parent or Guardian: ______________________ Date: __________

Doctor's Comments: ______________________

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Doctor's Signature ______________________ Date __________