Welcome To Our Office
Patient History & Information

Date:_____ **Cell Phone#**(___)_____ Referred By:_____

Patient's Name:_____ M__F__ _____ _____-____-_____
Last First MI Sex Birth Date Social Security #

Address:_____ (____)_____
Street City State Zip Home Phone

Email:_____ Employer_____

Preferred method of contact: email cell work home other_____

If over 18yrs and a full time student, name of college:_____

Spouse's Name:_____ _____
Last First MI Birth Date

Spouse's Employer:_____ (____)_____
Work Phone

Responsible Party:_____ _____
Last First MI Relationship To Patient

Address:_____ (____)_____
Street City State Zip Home Phone

Employer:_____ (____)_____
Name Street City State Zip Work Phone

_____ _____ _____-_____-_____
Occupation Birth Date Social Security #

Primary Insurance Co Name:_____ Group#_____

Subscriber:_____ _____ _____-____-_____
Last First MI Birth Date Social Security #

Employer:_____ _____
Relationship To Patient

Secondary Insurance Co Name:_____ Group#_____

Subscriber:_____ _____ _____-____-_____
Last First MI Birth Date Social Security #

Employer:_____ _____
Relationship To Patient

EMERGENCY CONTACT:_____Relationship_____Phone_____
Last First

Please be aware of the following:

***Antibiotics & other medications may reduce the effectiveness of oral contraceptives**
***In rare cases, patients may suffer unusual reactions to dental treatment, materials, or local anesthetic such as permanent numbness**
***Amalgam (silver) fillings contain mercury, which may pose health risks**
***I have received a copy of the CA Dental Board Dental Fact Sheet, and HIPPA disclosure**
***Patient/Responsible Parties are financially responsible for all treatment fees, regardless of insurance coverage**

I consent to treatment as necessary or desirable for the well-being of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations, use of laboratory diagnostics, x-rays, laser treatment, or any other procedures that may be used by the attending doctor or qualified designate.

I also acknowledge full responsibility for the payment of such services and agree to pay them, in full, AT THE TIME OF SERVICE, unless other arrangements are made with the financial department.

APPOINTMENTS CANCELLED PRIOR TO 48 HRS. OR NO SHOWS ARE SUBJECT TO A CANCELLATION FEE

Signed_____
Patient, Parent, or Agent (must be 18yrs or older)

Health History

Purpose of today's visit: Complete Examination____ Pain____ Broken tooth____ Other_____
Date of last dental exam:_____ Dentist:_____ Phone number: (____)_____
Do you have any conditions in your mouth that concern you?_____ If so, explain?_____
How often do you brush?_____,Use dental floss?_____ Are you worried about receiving dental treatment?_____
Have you experienced any unfavorable reaction to previous dental treatment?_____
Date of last medical exam:_____ Physician:_____ Phone number: (____)_____
Is your general health good?_____ Has there been a change in your health within the last year?_____
Have you been hospitalized or had a serious illness in the last three years?_____ Why?_____

Have you ever had a <u>serious</u> experience with:(circle answers)

Chest pain (angina)?	Yes	No	Dizziness?	Yes	No
Swollen ankles?	Yes	No	Ringing in ears?	Yes	No
Shortness of breath?	Yes	No	Headaches?	Yes	No
Recent weight loss, fever, or night sweats?	Yes	No	Fainting spells?	Yes	No
Persistent cough, coughing up blood?	Yes	No	Blurred vision?	Yes	No
Bleeding problems, bruising easy?	Yes	No	Excessive thirst?	Yes	No
Chronic sinus problems?	Yes	No	Frequent urination?	Yes	No
Difficulty swallowing?	Yes	No	Dry mouth?	Yes	No
Diarrhea, constipation, blood in stools?	Yes	No	Jaundice?	Yes	No
Frequent vomiting, nausea?	Yes	No	Joint pain, stiffness?	Yes	No
Difficulty urinating, blood in urine?	Yes	No	Seizures?	Yes	No

Do you have or have you had:

Heart disease?	Yes	No	AIDS?	Yes	No
Heart attack, heart defects?	Yes	No	Tumors, cancer?	Yes	No
Heart murmur?	Yes	No	Arthritis, rheumatism?	Yes	No
Rheumatic fever?	Yes	No	Epilepsy?	Yes	No
Stroke, hardening of arteries?	Yes	No	Skin diseases?	Yes	No
High blood pressure?	Yes	No	Anemia?	Yes	No
Asthma, TB, emphysema, lung disease?	Yes	No	Syphilis or gonorrhea?	Yes	No
Hepatitis, other liver disease? Type____?	Yes	No	Herpes?	Yes	No
Stomach problems, ulcers?	Yes	No	Thyroid, adrenal disease?	Yes	No
Diabetes?	Yes	No	Kidney, bladder disease?	Yes	No
Family history of diabetes, heart problems, tumors, high cholesterol, or gum disease?				Yes	No

Allergies to medications, foods, LATEX products, etc… **Yes** **No**
If you answered Yes please list allergies:_____

Do you have or have you had:

Psychiatric care?	Yes	No	Taken phen-fen/Redux?	Yes	No
Radiation treatments?	Yes	No	Taken Fosamax/bisphosphonates?	Yes	No
Chemotherapy?	Yes	No	Blood transfusions?	Yes	No
Prosthetic heart valve?	Yes	No	Pacemaker?	Yes	No
Artificial joint?	Yes	No	Contact lenses?	Yes	No
Do you have or have you had any other diseases NOT listed on this form?				Yes	No
If so explain:_____					
Do you take: Recreational drugs?	Yes	No	Tobacco in any form?	Yes	No
Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?				Yes	No
Please list:_____					
Women only: Are you or could you be pregnant or nursing?				Yes	No

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication.

Patient's signature:_____ ***Date:***_____